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AUTHOR	Lusky, Richard A.; And Others
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ABSTRACT

This learning module is one of three training modules that were developed for members of the Texas Gerontological Consortium for Continuing Education to use in preparing case managers working in human service professions coordinating community-based programs for frail elderly Texans. Module III deals with the following topics: implementation (case management agencies that provide services, communities with inadequate resources, working with families and providers, sharing consumer information, community resource inventories, sources of conflict); monitoring (types of case management monitoring, monitoring roles, frequency of home visits, monitoring and communication); reassessment (purpose, focal topics, and frequency of reassessment and care plan updates); closure (preparing for closure, common reasons for closure, maintaining relationships/contacts following closure); and evaluation of case management activities (rationale and components of program evaluation and quality assurance, blending program evaluation and quality assurance, principles for conducting program evaluation and quality assurance; rationale for a new model; a priority on service interaction; continuous quality improvement; Deming's 14 points and 7 deadly diseases; contrasting quality assurance and continuous quality improvement; and class activity). Included in the module are the following components: estimate of time required to complete the module; a list of suggested videos; and topic outlines containing topic objectives, the information to be learned for mastery of each topic objective, six references, and transparency masters. (MN)

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A STANDARDIZED CERTIFICATION PROGRAM FOR CASE MANAGERS SERVING FRAIL ELDERLY TEXANS

MODULE III

This project was supported by award number 55110004 from the Texas Higher Education Coordinating Board, Austin, Texas. This Carl Perkins award was designed to develop three training modules to prepare case managers working in human service professions that coordinate community-based programs for the elderly. The training material was developed for use by members of the Texas Gerontological Consortium for Continuing Education.

Richard A. Lusky, Ph.D., Project Director
Donald R. Louis, Ph.D., Project Coordinator
David S. Boyd, M.A., Project Consultant

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IMPLEMENTATION, MONITORING, REASSESSMENT & CARE PLAN ADJUSTMENT, CLOSURE, AND EVALUATION

MODULE III

Time Requirements of 20 Hours

Suggested Videos for this module:

- Medication use by the Elderly
- Medicated Generation
- Continuous Quality Improvement in Long-Term Care

TOPIC

A. IMPLEMENTATION OF CARE PLAN

AT THE COMPLETION OF THIS SESSION, THE PARTICIPANT WILL BE ABLE TO:

OBJECTIVES

1. The participant will gain an understanding of an overview of the implementation phase.
2. The participant will gain an understanding of tendencies with agencies that provide both case management and case management services.
3. The participant will gain insight into what they can offer when community-based services are inadequate.
4. The participant will learn the basics of working with the family, service providers, and within the case management agency.
5. The participant will gain insight into what information on a consumer to share with each provider.
6. The participant will understand the importance of knowing available community resources.
7. The participant will gain insight into potential problems encountered in the implementation phase.

Overview of Implementation

The service arrangement function of case management is the process of contacting both formal and informal providers to arrange for services outlined in the care plan. Case managers are involved in negotiating with a host of providers for services that both meet the consumer's needs and are cost effective. Practicing case managers believe that this is made much easier when agreements have previously been established between the case management agency and providers, either informally or through formal written agreements such as a memorandum of understanding. In some cases it becomes necessary to negotiate patterns of visiting of several providers to ensure timeliness of services. Implementation must be accompanied by cooperation of family members and they must be kept informed of who and what provider(s) is/are being utilized.

The characteristic that most distinguishes good case management programs from mediocre ones is **thorough** care plan implementation--the breadth, intensity, and skill of follow-through. Generally case managers know much more about implementation than they use, generally because they are constrained by time and budget. Case managers can also be discouraged by administrators who evaluate personnel by their performance in other tasks at the expense of not including care plan implementation tasks. Some administrators discourage case managers from partaking of any action that can evoke conflict. Aggressive care plan implementation sometimes calls for risking conflict and always bears the risk of making mistakes. At the same time the troubleshooting, problem solving and task achievements in care plan implementation are the most gratifying parts of the case manager's job (Steinberg & Carter, 1988). Implementation is the key to client satisfaction and benefit.

Each case management agency accommodates to and then tries to influence the conditions of its local service network by developing different kinds of relationships with relevant agencies. Case managers will need to make referrals to and receive referrals from a wide range of agencies on an as-needed basis, but they will need to have more firmly on tap a set of services most frequently needed by a frail elderly population. Implementation by its very nature implies the need to engage in advocacy to promote the development of needed services in a particular community.

The implementation phase of the care plan, which is based on assessment often can show inadequacies in assessment or perhaps the care plan is not realistic. This is a result of not all the functional facts being teased out in the open. Sometimes the case manager should have investigated further or the consumer failed to disclose information critical to their functional need. Therefore in implementing the case plan, the case manager might end up with an early revising of the plan. This further takes the edge off of the need for a precise assessment.

Implementation requires the case manager to apply specifics to the care plan. For instance, if the case manager, through the care plan, identified a housing change as essential for independent living, such as to assisted living, the implementation phase requires an examination of the consumer's resources to see if they can afford the assisted living options in the community, or if a specific option exists at all.

Tendencies when Case Management Agencies Provide Services

Implementation is a matching of resources with the problems identified in the assessment and the solutions as set forth in the case plan. In unusual cases the need may be present for the case management agency to have some crucial services in-house to be used without the delays or other disadvantages of interagency referral or purchase agreements. At the same time, many evaluation studies, along with the wording of the Older Americans Act, conclude that a case management agency should not provide direct service. This point of view arises from the following tendencies:

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overhead -- tendencies resulting from case management agencies being service providers.

- Case managers can develop a bias in favor of using those services rather than tailoring the care plan to the individual client ("You need --we have" logic).
- When a case management agency must monitor the quality and quantity of other agencies' service delivery, its own services must be beyond reproach or else program monitoring authority will be weakened and case advocacy will be compromised (people in glass houses---).

- When an agency has limited resources and carries both coordinating functions and direct service functions, the direct service demands for time and resources prevail over the needs of the case management program (daily routine displaces planning).

Most sources report that at present, the majority of case management programs for the elderly are located in agencies that also deliver direct service, and in those settings effective case management is taking place (Steinberg & Carter, 1988; Applebaum & Austin, 1990). Practicing case managers generally believe that the key issue is not the determination of the case management agency offering services, rather that if it does offer services that the case management component be located and aligned with administration. This placement within administration tends to free case managers from the tendencies mentioned above as well as to facilitate staff expertise with a focus on coordination functions. Therefore, the case manager is not merely an adjunct of the delivery of a particular service.

Communities Lacking Adequate Resources

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overhead -- communities with inadequate resources

There are many geographical locations in Texas, as well as other rural areas of the country where community-based services are lacking both in quantity and quality. The question then arises as to the efficacy of case management, without corresponding services, to be a valid force in keeping at risk seniors from premature institutionalization. Front-line practicing case managers generally believe that it is still worthwhile to establish a case management program even in those communities where supporting basic services are not fully in place. Common reasons include:

- The case management program can help to obtain more appropriate utilization of what does exist, including institutions, and thus improve options for seniors at risk of institutionalization.
- An effective case management program assists in documenting service gaps and in developing new, needed services; thus case management can be viewed as a catalyst for filling service gaps and upgrading the quality of existing services.

- Some of the chronically impaired elderly either do not need formal services or do need assistance with understanding their needs and overcoming their own resistance to accepting help before they can utilize services. Others need moral support for mobilizing their own capacities for self-help and for reinforcing their natural/informal systems. Therefore, the case managers can offer assistance in a planning and action process that in the short range may not call for coordinating formal services.

The above assumptions reinforce the position of this training effort by emphasizing that a major component of case management is the provision of a service that assists consumers in a problem-solving process of identifying needs, exploring optional solutions and mobilizing informal as well as formal supports necessary to achieve the highest level of independence possible. The implementation phase should trigger a reminder to the case manager that service coordination applies both to the maintaining of at-risk elderly persons in their homes through the packaging of community-based services, as well as for persons in nursing homes who might be seeking alternatives if those supports were available.

Working with the Family, Providers, and Other Agency Personnel

When the service or care plan is ready for implementation, a number of tasks need to be performed with the consumer and the consumer's natural support system (informal), with other agencies that will be providing services and within the case management agency. The tasks of implementation include the following:

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overhead -- working with the natural/informal network

- giving information about services to come;
- modeling behaviors in how to secure services;
- providing support or sharing responsibility for obtaining services;
- counseling or understanding problems, seeking solutions, carrying out plans for change, evaluating changes;
- helping out with a specific task or doing it for the consumer;

- confronting the consumer with how he/she may be exacerbating own problem;
- preparing for reductions or termination of services.
(Steinberg & Carter, 1988, p. 25).

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overhead -- working with service providers

- informing agencies about the case manager's work with the consumer;
- purchasing services (if provided in care plan);
- encouraging providers;
- monitoring the delivery of service;
- mediating conflicts between providers or between consumer and provider;
- becoming an advocate or ombudsman when necessary to obtain or correct a service;
- correcting resource files (or service directory) to reflect actual performance of providers;
- creating new service for a consumer or class of consumers;
- identifying and reporting barriers to service delivery;
- troubleshooting arrangements with landlords, utility companies, tax officials, zoning or sanitation departments.
(Steinberg & Carter, 1988, p. 26).

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overhead -- working within the case management agency

- informing ancillary personnel as needed;
- reporting barriers created by agency policy or procedures;
- making and updating reports essential for case records, administration or evaluation;
- obtaining consultation if needed.
(Steinberg & Carter, 1988, p. 26).

Additional case management concerns emerging from the implementation phases include:

- comprehensiveness--offering sufficiently divers e service options to span the diverse needs of its clients;
- continuity--coordinating the movement of consumers through changing levels or types of care;
- adequacy--ensuring the available supply of eac h kind of option, and
- quality--providing services that meet performance standards that protect vulnerable consumers.

Sharing Consumer Information

A key aspect of service arrangement involves sharing consumer assessment and care plan information with all relevant informal and formal providers. Although families provide 80 percent of all service consumers receive (Brody, 1986), a criticism of family members, according to practicing case managers, is that frequently they are not informed about what formal services will be provided to their parent or what the family is expected to do as part of the care plan. In addition, physicians are critical of community-based services because they are seldom informed regarding how the services they have ordered will be provided. As a result, providers involved in care plan decision-making can lack adequate information.

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overhead -- sharing consumer information

Practicing case managers note that the original consent form signed by the consumer gives permission for the case manager to share personal information, yet information can be sensitive and all providers must share a common bond of treating information with confidentiality. Without the release of necessary information, providers fail to get the complete picture of the level of functioning of the consumer. The release of information is critical to efficient implementation of the care plan.

The consent form gives the case manager the legal protection to share information with other providers. This protection is extended only to the providers providing the service(s) that are needed to meet the consumer's needs as set forth in the care plan. For example, the case manager does not share nutritional information with a provider of another specific service such as transportation. The consumer's signing of the consent form is giving the case manager the right to share information only in the categories of services identified as needed in filling an identified gap in service. If an area of service need is not identified such as home repairs, when the consumer signs a release, then information regarding the need for home repair cannot be discussed with other providers.

Practicing case managers view their primary problem with implementation is the need for everyone involved to have the same respect for privacy and confidentiality of the consumer on personal information. Besides the legalities involved, providers often fail to grant common courtesy with respect to privacy. It is through networking that providers learn to share a common value system with respect to privacy. Some agencies use a written statement from each employee of a provider with which they broker a service documenting that they will respect confidentiality. This serves to reinforce and elevate the status of consumer confidentiality.

As mentioned above, the flow of information must include the physicians as they want to keep abreast of their patients, however it is particularly important to keep the physician's head office nurse informed with the status of the case management consumer. Maintaining the physician in the informational loop also serves to keep the physician as a team member.

Resource Inventory

Throughout Module I emphasis was placed on the need for the case manager to be an active and visible member of the elderly service providers' network. Such involvement assists the case manager with the establishment and maintenance of an inventory of resources necessary when packaging needed services. Practicing case managers place considerable emphasis on the need for being acquainted with other key professionals, which eases the process of seeking their involvement when the occasion presents itself. Professional linkages also broaden the base of ownership or state in the case management program. "What people are not in on, they are down on" is a basic principle of community organization. For the beginning case manager, the development of an inventory is not merely an accumulation of data to be organized into a printed directory, rather it requires an ongoing process of updating, verifying and expanding of data, and a periodic assessment of whether the form and content facilitate case management services. The field of providers is often in a state of flux with new providers entering the field, personnel changes or the mergers of various groups, particularly large hospital owned groups.

The need for a personal knowledge base of community-based services available can offer time-savings when a need does present itself. One of the difficulties in searching out available services within a community is the lack of widely understood terms or accepted definitions of services. Terms such as *homemaker, housekeeper, chore service, home maintenance or home health aid* can have divergent implications depending on the community. Another important example in Texas is *respite service.* Respite services are seldom found in the yellow pages of a telephone directory, yet various services are used for the purpose of providing respite, such as adult day care, various visitor programs, nursing homes, or in some instances a separate program sponsored by the local Area Agency on Aging (AAA).

An important aspect of inventory development and maintenance, as mentioned earlier, is the establishment of good working relationships with other organizations in the community. The manner in which these tasks are performed will affect, positively or negatively, the many other case management tasks to be done. The number and characteristics of resources included in the inventory will vary greatly with the size of a particular community and the relative complexity of its service system. Small towns and rural areas usually have a strong focus on informal support from churches and civic groups.

The care plan development training addressed the need for involving in the planning of the coordinated service program all those agencies and organizations whose cooperation is essential to implementation. This again is emphasized here for the sake of assisting with efficiency when implementing the care plan. While there may be a limit to the number of formal coordinative relationships a case management program can carry, the number of informal relationships is infinite and equally important. Regardless of the nature of the linkages (formal or informal), they must be reinforced by interpersonal relationships and participatory exchanges. Often informal cooperation may be the prelude to formal agreements and procedures.

Case managers report that with respect to a pool of resources, through informal meetings of all providers, the stage is set for a community pool of resources where everyone is familiar with services of that community. Most communities have a resource directory of all providers and what services they offer. It is important that the case manger know all the resources available in a community. If a resource directory is not available, then the case manager should create their own. Various opportunities are present for the case manager to link with others in the aging network, such as a hospital discharge planner, who can offer valuable assistance when trying to implement a service from a provider that is new to the case manager. It is also recommended that a beginning case manager should make visits to contractors to develop relationships and gain insights into their philosophy and find those who share similar positions as your own.

Implementation can involve assistance with processing various applications, of which the primary one is with the Department of Human Services in seeking Medicaid for qualified consumers. The case manager has to request the application from the Department of Human Services, meet with the consumer or their family, supply appropriate documentation regarding income, other aspects of the application phase with that program or other programs that are essential for the consumer's ability to remain in their home. In such cases, implementation can involve a very lengthy paperwork trail.

Sources of Conflict

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overhead -- sources of conflict

Implementation can be a source of conflict for the case manager. Conflict with other providers generally is not a major problem, aside from typical personality conflicts. Implementation is the beginning of documentation as far as frequency of a particular service. Implementation involves planning ahead as to when reassessment will occur and when the case manager will do the next monitoring. A source of conflict can occur when documentation is inadequate; for as the agency's client base grows, it is impossible for the case manager to remember everything. Implementation forces case managers to see the realities of the consumer's functioning and come to grips with the fact that at times, whatever the package of services, it may not be enough to stave off nursing home placement. In some instances the service needed may not be available. Another frequent problem is one of logistics such as providing a specific identified service in a romote geographical area.

A very frustrating conflict arises when a consumer may request a service and then deny they really need it. Some consumers have a problem when they come face-to-face with the idea that they really do need assistance with activities that they provided for themselves and were taken for granted. The problem then is the consumer's compliance with the specifics of the care plan. This factor presents itself generally with consumers who have short-term memory loss such as with a dementia. This is particularly true when family members deny the presence of a dementia. Implementation can tease out family problems not fully identified during the assessment phase. Families can sabotage the entire implementation process if they are not open to the actual insertion of a professional care-giver into the life of the consumer.

Conflicts can arise in the implementation phase when there is a duplication of services. An example of service duplication could be that of an assessment indicating the need for homemaker services and at the same time, the consumer is receiving, via skilled home health care, the assistance from a home health aide. The case manager cannot implement the homemaker service, due to duplication of services, until the home health aide is withdrawn as a result of the consumer exhausting Medicare benefits for the home health assistance. Another example is the case manager identifying the need for transportation assistance, and available transportation does not serve the location.

Summary of Implementation Phase of Case Management

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overhead--summary of implementation phase of case management

The purpose of implementation is to arrange and ensure that services and other help are provided and utilized effectively. Implementation is the action phase of the care plan and involves clear delineated lines of who provides support and follow-up functions. Implementation can involve a search for or the creation of new services, the monitoring of service providers, the arrangement for reimbursement for services, monitoring of consumer acceptance of services, as well as satisfaction, troubleshooting bureaucratic barriers, providing counseling to consumers and their families, the authorization of service provisions when the case manager controls the funds and the participation in case conferences, frequently by telephone. Implementation requires role clarity among staff, functional differentiation among agencies, time budgeted for follow-up and continuous supportive interpersonal communication.

Implementation is very gratifying, the case manager sees the fruit of their labor and needs to enjoy the moment. Whenever there is a successful match of provider with the needed intervention, there is tremendous sense of accomplishment. Case managers generally express a deep sense of gratification to see that a consumer is benefiting from a service.

TOPIC

B. MONITORING THE CARE PLAN SERVICES

AT THE COMPLETION OF THIS SESSION, THE PARTICIPANT WILL BE ABLE TO:

OBJECTIVES

1. The participant will gain an insight into the broader meaning of monitoring care plan activities.
2. The participant will gain an understanding of the various types of monitoring.
3. The participant will gain an understanding with respect to the freqency of home visits.
4. The participant will gain an understanding of the role of communication during the monitoring phase.

An Overview of Monitoring

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overhead -- monitoring defined

Monitoring is continued contact by the case manager to ensure that services are provided in accordance with the care plan and includes ascertaining whether these services continue to meet the client's needs. Monitoring is a critical case management task that enables the case manager to respond quickly to changes in the consumer's status and maintain, increase, decrease or terminate services as indicated. A major component of monitoring means a visit to observe if the service being provided is the solution as identified in the initial assessment thus written in the case plan. Monitoring activities, as set forth by the Texas Department on Aging (1991), includes:

> performing necessary activities to ascertain the delivery of planned services and whether or not the service was successful in meeting the need, and advocating for improvements in service delivery. Monitoring includes at least monthly contacts with the consumer and with their service provider(s), and a home visit at least quarterly.

Responsiveness to changes in consumers' needs can have a dramatic impact on service costs. The frequency of monitoring varies depending on the intensity of consumer needs and the type of services being delivered. For example, a consumer who has just been discharged from the hospital after an acute illness and is temporarily receiving home health care from two shifts of in-home workers may need substantial monitoring. Consumers who are in crisis situations or whose circumstances are more complex should be monitored by case managers and other professionals whose skill levels are sufficient for the task. Occasional monitoring may be all that is required by a consumer who is stable and receiving meals and weekly personal care.

The care plan is designed to address the problems identified in the assessment process. This training has sought to emphasize the point that for the vast majority of case management consumers, the point of entry is through the hospital as the result of an acute episode. For the elderly, the healing or adjustment process can be slow, yet the plan and the corresponding services must continue to reflect the presenting problems. As conditions change, whether in a positive or negative manner, the match between the care plan, services and the consumers' needs must reflect accuracy. Not only is the case manager monitoring for the correct match between problems identified and services provided, but for other consumer problems that are treatable (Applebaum & Austin, 1990). Thus, monitoring has two components: the first one is mechanical or the physical knowledge that a given number of units of a service are being provided to a consumer, and the second is that the case manager is monitoring the consumer for level of functioning by comparing their (the consumer's) functional ability at a given point in time compared to when the services first began.

Monitoring is a mechanism for accountability and for technical assistance. It is a form of surveillance and support in which the coordination agency engages the providers of service. The degree of authority and intensity with which the case manager handles monitoring functions varies with different agencies and their contexts.

Types of Case Management Monitoring

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overhead -- types of monitoring

Authority for monitoring is strongest in those case management programs where the coordination agency is paying the provider. However, it does not hold that all the case manager needs is the power of the purse strings to influence the quality of the service provided. Sometimes the understanding and expertise of the monitoring case manager in helping the provider to solve problems is a more effective force for change.

The power to withdraw funds from an errant provider agency is rarely used, because this would also deprive consumers of the service, especially in communities where no alternative providers are available. In addition, some community-based providers have a larger, more committed constituency or more status at higher levels of the hierarchy than the case-management agency. Such constituency-based power can compromise the power of the purse strings, placing a heavy responsibility on the agency to prove its case when threatening withdrawal of funds. Nevertheless, in this arrangement the legitimacy of monitoring the services for which one pays is seldom challenged.

A second type of monitoring occurs when the case-management agency is mandated to monitor a service provider on behalf of a funding source, but without serving as a vehicle for the actual dollars. An example of this is when a county government provides revenue-sharing funds directly to a nongovernmental provider but wishes to have the program monitored by an appropriate existing county agency such as a county committee on aging that offers case management. Formal program surveillance is relatively limited since the case management agency is not directly accountable for the proper expenditure of funds. Case-by-case troubleshooting is improved by this type of arrangement.

A third type of monitoring is less formal in that it does not appear in a statue, regulation, contract or written agreement. This is the monitoring of agencies to which consumers have been referred in the traditional way, without purchase or without a legal mandate to monitor. Frequently case managers receive referrals where only one service is needed such as meals-on-wheels, in which case assistance is given for securing the service, yet the consumer is never formally accepted as a client as the need cannot be justified. While many programs and front-line practitioners do not do as much follow-up of referrals as they deem desirable, it is a commonly acceptable practice, consistent with professional ethics, that a case manager "check" on how well a referral worked for the consumer both with the consumer and with the agency to which the referral was made. Case managers working with the frail elderly can legitimately do this kind of follow-up to referrals. The legitimacy derives from mutual concerns for the interests of the consumer rather that one agency's authority over another.

Monitoring Roles

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overhead -- monitoring roles

The case management agency and its case managers have a variety of roles in monitoring. The following are five distinct roles with accompanying examples:

- Validating that the provider agency is delivering the quantity and quality of service that it has promised is monitoring for compliance. Tasks may include the review of written reports with summary data on utilization and expenditures, the examination of sample case files, study of requested written reports on individual clients, observation at the service site and interviews with staff and consumers.
- Providing moral support and technical assistance to the provider in solving program-wide as well as

case-specific problems is another role. The monitor may use some of the same activities mentioned for the first role plus consultation conferences and staff meetings. In this role it is essential that the monitor have a counterpart--a staff member in the provider agency who has a day-by-day responsibility to solve problems within the agency. This role sometimes calls for the monitor to help the provider obtain specialize d technical assistance from other personnel in the case-management agency or from other cooperating sources.

One of the most effective tools for helping providers to improve their practices is for the monitoring case manager to arrange for interagency meetings of those with similar services so that the cluster of agencies can help one another to arrive at solutions to problems. In the short run there is some risk that agency frustrations will lead to gripe sessions about the case management agency. In the long run, however, monitoring case managers may discover how their own agencies may be contributing to the problems or standing in the way of the solution. At the same time interagency meetings may develop peer pressure for its members to improve and then may give recognition and positive reinforcement to those who make effective changes. Similar assistance my sometimes be needed from the provider's national standard-setting body or state licensing agency.

A third monitoring role is addressed to the consumer. Through telephone and in-person contacts, such as in-home visits, the case manager verifies that the consumer has taken the necessary steps to utilize the service appropriated and that it is being delivered. If problems exist that have to do with the consumer's attitude or behavior rather than those of the service provider, then the case manager seeks to assist the consumer through counseling, obtains counseling from another source, or works with the consumer to revise the care plan to better suit the consumer's preference. In the process the case manager can clarify whether the reluctance to use the service stems from misunderstandings, conflicting opinions in the family, mistakes by the service provider in its initial contacts with the consumer or a faulty assessment and care plan on the part of the case manager.

- Teaching consumers to monitor their own caregivers is a fourth role. It is increasingly common for case managers to meet with family members and friends individually and in natural support network meetings at which the consumers are invited to "let the case manager know" if service delivery is not satisfactory. A more formal method of engaging the consumer in monitoring used by one case management agency involves consumers being given a monthly calendar on which the case manager recorded the scheduled in-home services. Consumers were asked to mail back the calendar each month with comments as to whether satisfactory services were received as scheduled.

- Evaluating the effectiveness of service delivery in particular cases is the fifth monitoring role. Here we refer to the art rather than the science of evaluation. The preceding four monitoring roles are concerned with whether the intended services were received in the intended manner. They represent monitoring of performance, not of impact. The care planner's assumptions are that if the intended services are delivered that the possible achievement of the case goals is enhanced.

  In some instances the case manager becomes aware that the services are not having their appropriate effect or that they are producing unintended, undesirable side effects. For example, the consumer may be becoming overly dependent in order to enjoy the company of visiting aides or the family may be experiencing excessive depression due to increasing care demands as the homemaker is being phased out. This kind of clinical monitoring can lead to reassessment or modifications in service plans. For example, the case manager may conclude that it would be more nurturing and less stressful for the son to prepare the food (rather that use meals on wheels) instead of assisting in toileting and changing dressings (which can instead be done by a home-health aide). Since this kind of monitoring is based on discretionary judgment, it is helpful to consult with supervisors or convene a case conference of relevant care givers to confirm the case mangers perceptions (Steinberg & Carter, p. 85).

Frequency of Home Visits

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overhead -- frequency of in-home visits

The case manager visits in the home at a minimum, at intervals prescribed by the regulatory standards governing the agency. Practicing case managers generally report that under circumstances where the consumer's condition is stable, a visit should be at least once per calendar quarter. Many case managers advocate for a home visit at least once per month, with that visit being unannounced. The visit should correspond to when the homemaker is there or a meal arrives. Monitoring frequency depends on the intensity of the consumer's circumstances, thus evidenced by the care plan. Monitoring should always occur sometimes toward the close of the first month, then every three months if there are no problems. Title three monies supporting case management carries a requirement of a monitoring entry in the case management log every three months. Case managers generally contact every consumer at least once a month over the telephone, which is in addition to any home visits.

Telephone conversations can be at frequent intervals with nearly every consumer during the initial implementation of services. The frequency can be more than once a day until a situation does stabilize and at least once a week until the consumer's situation is stable. The case manager is monitoring to see if the services that were implemented worked and were the results positive. The case manager is also monitoring for other important aspects of a consumer's life, such as did they make their appointment with their physician. When initial intervention is the result of a health condition, the monitoring phase is a check on that condition, specifically observing for any changes in condition, either positive or negative.

Many case managers make a home visit close to the end of the first month the consumer is on services. This visit is in fact a mini-reassessment, as the case manager is comparing what they find with what is intended, based on the initial assessment and the interventions as set forth in the care plan. This visit is one means of finding out the consumer's satisfaction with a service, which is important to the success of the case management agency. At the time of this visit at the end of the first month, the initial assessment instrument is used as a valuative check by which comparisons are made with conditions at the one month interval. The case manager will visit the consumer more often if:

- the case manager perceives a need for a visit based on the telephone conversation or other information from a service provider;
- the consumer is discharged from a hospital;
- there is a change in the formal or informal support system due to a major change in the family;
- there are specific housing or environment issues such as threatened eviction or regulatory complaints such as from the health department;
- there is a change in the consumer's living arrangement;
- a vendor of community agency reports a perceived change in the consumer's physical or mental health status;
- there is a change in the consumer's financial situation or ability to manage finances such as requiring money management.

Monitoring Involves Communication

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overhead -- monitoring involves communication

The monitoring phase of case management, depending upon an individual consumer's situation, requires communication with family members and the following agencies in order to ensure the consumer's needs are being met:

- consumer and consumer's family
- personnel with home health agencies, including hospice
- personnel with providers of homemaker services
- transportation providers
- drivers delivering home delivered meals
- grocery delivery personnel
- physician
- hospital social worker should consumer be in hospital

The beginning case manager should exercise caution with the degree of accuracy in a consumer's self-reporting. Through knowing the consumer, the case manager quickly learns the degree of accuracy in what the consumer is reporting with respect to quality, quantity and degree of satisfaction of services currently being received. Practicing case managers generally find self-reporting very inconsistent, thus the case manager has to be aware of clues to determine the success of the service. The reason for hands-on monitoring is also to further develop the relationship with the consumer, and through this relationship the case manager can determine the actual picture and sense of accomplishment through the services being provided. Some consumers will always say everything is fine, when in fact it is not, and some will report everything is negative, when in fact the effects of the service are positive. Thus a telephone call can fail to give an accurate picture by which to monitor a case. Monitoring is a check on the consumer and also the impact of the care plan you and the consumer developed.

Monitoring is written in narrative format. Brief entries are written such as "Mrs. Smith is doing fine," or "services seem satisfactory." Some agencies make use of an *activity slip* that is used to document every telephone call with a consumer. This tells what the conversation was about, with the activity slip placed in the consumer's file. The same procedure is followed with conversations with providers. These can be rather extensive during the first few days of implementation.

TOPIC

C. REASSESSMENT & UPDATING THE CARE PLAN

AT THE COMPLETION OF THIS SESSION, THE PARTICIPANT WILL BE ABLE TO:

OBJECTIVES

1. The participant will gain insight into common reasons for reassessment.
2. The participant will learn the focal points of the reassessment process.
3. The participant will learn about the frequency of reassessment.
4. The participant will gain insight into updating the care plan.

Reasons for Reassessment

Reassessment is the scheduled or event-precipitated examination of the consumer's situation and functioning to identify changes that have occurred since the initial or most recent assessment in order to measure progress toward the desired outcomes outlined in the care plan. Reassessment intervals should be specified in the initial care plan, such as every three months, and vary in frequency depending on the consumer's condition. The case manager must also monitor changes in family structure and family involvement as part of the informal caregiver network.

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overhead -- TDoA's description of reassessment

The case management standards produced by the Texas Department on Aging (1991) gives the following description of reassessment:

> Periodic reassessments are conducted either when the case manager's regular monitoring indicates that the consumer's condition has changed, or when a caregiver reports to the case manager that the consumer's condition has changed. Reassessments include contacting the consumer, the family or friends or the service providers and applying case management procedures to newly discovered or still unmet needs.

Reassessment requires the use of many of the same skills as the initial assessment; it must be functional in nature, and the case manager must know the basics of normal age-related changes. Reassessment often is the result of the initial problem being resolved or redefined. Reassessment requires that the care plan be updated and services altered as circumstances dictate. The following are common reasons for reassessment:

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overhead -- common reasons for reassessment

- medication interaction;
- change in informal network, e.g., death of a consumer's spouse or member of the informal caregiver network;
- acute health conditions causing hospitalization

or temporary placement in a nursing home;

- when a new unanticipated crisis or impairment befalls the consumer or family that involves abrupt functional changes;

- standardized intervals prescribed by agency policy, such as six weeks, three months or six months;
- on a schedule written into the care plan based upon the case manager's expectations;
- when a new case manager is assigned to the case;
- the presenting problem has been resolved, alleviated or redefined;
- when a planned service is discontinued by the service provider or the client;
- when there is planned withdrawal of a service or there is an unanticipated improvement in the client's situation, and thus a need to help the client to see the change in a positive light;
- when there is agency pressure to terminate improved or stable cases to make way for new, waiting consumers.

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show video - *Medication use by the Elderly.* Tell class that the elderly are high risk drug consumers and there are many hazards and complexities with their medications. The majority of case management consumers are entering from a hospital visit and there is a good chance that they are on new medication. It could be a few days before negative interactions could occur. Optional is the use of the video *Medicated Generation.* It tends to emphasize the role of the pharmacist, however the case manager will, on occasion be the interface between the consumer and the pharmacist or physician or both.

In general, reassessment is not as comprehensive and tends to be more brief as the case manager should know the consumer exceptionally well at this interval as a result of the case manager having developed a more in-depth knowledge of the consumer, particularly with respect to the accuracy of their self-reporting. Reassessment can lift any cloud off the original assessment, as the case manager has more information at this interval, giving a much more accurate picture of functional skills and gaps in service that might need filling.

Focal Topics at Reassessment

Reassessment in the "aging network" uses the same original form (form 2060) as it has a column for reassessment. The reassessment is a formal process that examines the same functional areas as the original assessment and not the minor adjusting of the care plan. Reassessment involves comparing what the case manager finds of a functional nature, at this interval, compared with the intake assessment. Reassessment is done after any hospital visit, as this usually signals an abrupt change and the need for additional services.

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overhead -- reassessment examines --

- functional level of consumer
- accuracy of care plan in addressing unmet needs
- degree of accuracy of the match between the consumer's needs and what services the care plan provides
- are the desired effects being achieved
- possibility of prevention goals
- the most cost effective approach being used to meet functional needs

Frequency of Reassessment

For many agencies, an assessment is considered original for the fiscal year, otherwise it is a reassessment. For these agencies, a new form is used at the start of every fiscal year using reassessment procedures. For consumers who go off services and re-enter at the same functional level, the intake process is considered a reassessment unless a new fiscal year has begun. Reassessment is anytime there is a need to drastically change the care plan. The case manager makes an arbitrary decision to do the reassessment. A change in the consumer's condition, either positive or negative, can trigger a reassessment. Reassessment can occur at any time there is a need based on consumer change (positive or negative) and the care plan fails to adequately meet consumer's needs. Anything can trigger a reassessment. For example, if a family member has been faithful in performing a necessary task, and that family member is suddenly removed from being part of the informal network, then the care plan needs to be updated.

Reassessment is mandatory every six months for agencies whose primary source of funding is Title III of the Older Americans Act. The interval is, in part, a function of an agency's policy, for example, such as requiring a mandatory reassessment be performed quarterly or annually. Practicing case managers believe that reassessment visits should be done at a minimum of every six months although it is recommended that most consumers be visited quarterly or more often, if needed. The typical consumer is evaluated every three months.

The reassessment should be an examination as to what extent the desired effects were achieved from the original care plan. If effective, the care plan is as much a part of the reassessment as the level of functioning of the consumer and the degree to which the original goals were met. Reassessment is an evaluation of the care plan. At the core of the entire case management process is the accuracy of the care plan and thus minor adjustments to the care plan occur on an ongoing basis and are not the result of a formal reassessment. Reassessment evaluates to ascertain if the care plan is remaining on target in terms of directing the correct resources and quantity of those resources to meet the consumer's needs.

All providers are trained to observe for functional changes and direct this information to the case manager. These tips can and should lead to a home visit on the part of the case manager. The purpose of reassessment is to determine whether services need to be changed in any way. Changes may include replacement of one service by another, modification of intensity of service or termination of services. These considerations apply not only to the services obtained through case management, but also to the service of case management.

Initial assessment was addressed in Module II of this series, directing the case manager to inform the consumer that the thrust of the assessment effort is to determine unmet needs and not a guarantee of service. The same message needs to be conveyed to the consumer at the time of the reassessment. The same mind-set needs to accompany the case manager during all follow-up assessments. Case management seeks to arrange for services not currently being provided by the informal network. A primary consideration for scheduled reassessments is not to create dependency by providing more services than are needed. The case manager should remember that it is easier to increase services than to decrease them.

It is important to keep in mind that service plans are not set in stone and often change as the consumer's needs change. The reassessment should identify when or if needs have been met, how services should be altered to meet them or establish new goals and strategies to address needs. Whenever it is determined that a plan is to be one of a short term duration, such as when a client has a fractured limb, when the caregiver will be away temporarily or when the consumer has demonstrated prior independence before and does not want services long-term, the case manager should note this in the narrative and the service authorization should be written accordingly. It is important that the client or family members understand any short-term authorization period.

To prepare for a reassessment visit, the case manager should review the report of the most recent visit and case progress notes. This visit is a good time to follow-up on any problems mentioned by other providers. At reassessment, the case manager makes use of the original assessment form and compares the consumer's current level of functioning with how it was at the time of the original or last assessment. The assessment is what the care plan is based on, and if reassessment indicates change, then the care plan needs an update. Care plans can be altered on a continual basis and must examine every aspect of the consumer's life. Case managers report that a frequent result of reassessment is finding functional improvements in one area with corrections needed in another area, such as personal care needs are adequate, yet socialization needs are lacking.

A case management agency requirement of a periodic reassessment directs the case management process away from crisis management to a formal organized process. The impact of a formally scheduled reassessment is one of directing the case manager to think in terms of preventive goals. Preventive goals are superior to crisis management, and this is a function of reassessment. Timely reassessment can indicate functional declines whereby the case manager can suggest and implement a service such as an *emergency response system*, rather than the consumer's family calling in at a later date and saying their parent spent the night on the floor as a result of a fall. Reassessment involves an attempt to forecast needs and take preventive steps to keep consumer in their home. The flow of information from a variety of sources should be of the magnitude that the case manager is aware of functional changes and therefore the results of the formal reassessment should not be shocking. All team players should be so focused on a consumer's functional changes that anyone will update the case manager through a telephone call.

Reassessment involves an examination of the most cost-effective services by which to sustain the consumer in their home. This can involve an examination of additional informal services such as those offered by a church that were not available at the time of the original care plan.

Care Plan Update

This can be formal or very informal as a process. Generally when a consumer expresses a strong sense of urgency during a telephone conversation, that consideration is added to the care plan at that interval. During home visits, special attention is given to those modifications authorized by telephone. The consumer does not have to sign an additional authorization to add a service, which might require the case manager sharing information. Practicing case managers caution that learned helplessness is a possible outcome of providing a service. The case manager must exercise caution and be attuned to this effect and this is one item to consider in updating a care plan.

It is necessary to prepare consumer for the withdrawal of services, assuming their condition is improving. This is documented in the care plan and also the consumer is told in advance as to the exact time a service will stop. A standard practice of case managers is implementing a slow withdrawal from a service such as reducing personal care services from three times a week to twice and to once, thus this is written in the care plan.

Case managers learn through practice the extent to which a consumer will probably be short-term or long-term. Short-term type consumers tend to come through the hospital system and will tend to recover or adapt; this is reflected in the care plan. Any update to the care plan will also reflect the duration and in the case of short-term consumers, specify an anticipated time when the services will be lifted. Consumers who have more long-term needs will have notes to that effect in their care-plan, and with these persons the case manager is generally adjusting the care plan for more intensive services. The physician's prognosis generally tells the case manager if the consumer will be short-term or long-term.

TOPIC

D. CLOSURE

AT THE COMPLETION OF THIS SESSION, THE PARTICIPANT WILL BE ABLE TO:

OBJECTIVES

1. The participate will gain an understanding of closure as a stage that is part of the overall planning process.
2. The participate will be exposed to common reasons for case closure.
3. The participate will learn that communication with consumer continues after closure.
4. The participate will gain an understanding of methods for maintaining contacts with consumers following closure.

Preparation for Closure

The majority of clients enter case management services following the onset of an acute condition. Recovery or adaptation for seniors generally has prolonged time requirements. Therefore, the majority of cases are regarded as long-term cases. However, case management requires that services be terminated when the consumer no longer needs case management or the services coordinated by case management. Many practicing case managers express a reluctance to terminate cases when there are improvements in the situation because it is then very cumbersome (with new paperwork) to reopen the case if changes occur later. At the same time, practitioners believe that in selected cases termination not only helps to reduce excessive case loads, but also makes it possible to elevate a consumer to a renewed level of independence.

It is essential that consumers be prepared for closure, and it is a good practice to prepare them for closure from the day of intake. This is a benefit and part of the rationale of the consumer's participation in the development of the care plan. Closure is never a surprise as a closure date is established as part of the original care plan. For every service put into the care plan, there is an accompanying remark on the expected length of service; therefore all providers, the consumer and the consumer's family are all aware of how long a service will be provided, assuming there are no negative changes in consumer's functioning. The original care plan will indicate an expected day of discharge. This reinforces with the consumer that, if their functioning improves, the service will be withdrawn on a predetermined day. Services are decreased in a corresponding manner as functioning improves so at closure there is not an abrupt stopping of a service. If consumer's functioning does not improve to the level at which services can be totally withdrawn, then services at the minimum level necessary to sustain functioning and basic task completion is left in place, accompanied with monitoring and periodic reassessment.

The case manager should start telling the consumer as far as a month ahead of time that "if they continue to improve, they will no longer need a service." Case managers must reinforce the fact that the consumer can call the case manager at any time after services are terminated. Sometimes, particularly in short-term situations, a first visit does not occur because the consumer's condition has improved and the case manager can tell by telephone that services are no longer needed. This is particularly true when the case manager's primary function is that of being a source of information regarding a specific service such as the implementation of meals-on-wheels.

Common Reasons for Case Closure

Closure comes about from an entire array of possible outcomes. Consumers can experience an improvement in functioning and not need services. Consumers can digress or a chronic condition can worsen such as cancer, in which case a hospice agency is involved. It is important not to withdraw services that are responsible for a consumer's improved level of functioning, or a particular service that is responsible for maintaining a level of functioning. This is one of the hardest decisions a case manager has to address, and that is what will happen if a service is withdrawn. Anytime a service is withdrawn, close monitoring is required so as to observe the consumer's level of functioning. Under optimal conditions, case managers can make mistakes and need to re-implement or restore a service. Frequently confidence on the part of the consumer is lacking or they develop fear that they are not up to the task of living independently without a service. Case managers must follow-up at periodic intervals following the withdrawal of a service to make sure the consumer is able to provide their own care. Case managers must inform the consumer, or their family members, that they are encouraged to call the agency and report any changes, particularly when those changes in functioning are negative. The case manager sends notification to consumer that services are ending. This is the documentation necessary for the consumer's record. This document does not require the consumer's signature.

The more successful a program is in targeting to the most vulnerable elderly, the greater the percentage of the caseload that is carried for the long term. There are a number of occasions, however, when cases are closed.

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overhead - common reasons for case closure

The following list represents the most common reasons for terminating clients (Steinberg & Carter, p.29).

- The consumer himself terminates.
- The principal service provider recommends termination.
- A single service provider accepts comprehensive responsibility for the care.
- The consumer enters another living arrangement.
- The consumer insists on services that the case manager thinks will be counterproductive or refuses recommended services.
- The presenting problem has been alleviated and the case manager thinks that the client or caretaker can carry responsibility for service procurement and task coordination.
- Demands for services and scarce resources make it necessary to set priorities among clients and withdraw services from those who can still benefit but whose needs are less hazardous than others.

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overhead -- closure as a result of nursing home placement or death

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A client's case may close for many reasons, however, in the incidence of the client's death, placement in a nursing home or relocation to another area, the case manager should consider the following:

- Confirm with the family/friends of the client that the information is correct.
- Notify all service providers and community resource providers who were involved with the client.
- Document why the case is closing and other pertinent details in the progress notes.
- Process necessary paperwork to close the case.

If the client is no longer "need" eligible for services based on his/her ability to complete activities of daily living such as bathing or meal preparation, the case manager will explain this determination of ineligibility to the consumer in person and give a two week notice of the termination of services. The client may sign the voluntary consent form agreeing to the termination of services, or the case manager may need to send a notice of action which allows the client to appeal the case manager's decision to terminate services to the agency's Internal Review Committee. The case manager may consider contacting the Volunteer Coordinator at any of the provider agencies to arrange for volunteer assistance if the client desires. Another alternative is to provide the client with a list of private pay resources or to refer the person to a private pay case management program. Then the case is closed.

Closure can be the stopping of formal services at such a time that those supplied by the informal network are adequate to meet all functional tasks. Sometimes this is the result of the case manager finding additional alternatives within the informal network. The case manager needs to remember that one of their primary roles is to expand and to empower the informal network to provide the services needed for independent living.

Case management consumers are monitored by a telephone for a month following the halting of formal services. Consumers who are discharged and sometimes later experience a condition, generally another admission to the hospital, the situation is treated as a new admission in terms of assessment and care plan development. Closure can also be the placement of a consumer in an alternative setting such as assisted living or nursing home. If the client is placed in a nursing home, the case manager will keep the case open for two weeks to one month to ensure the placement is indeed long-term. At the end of this period, the case manager will contact the family or nursing home personnel to confirm the living arrangement. If confirmed, the case will be closed.

Closure can be the source of mixed emotional reactions for the case manager. On the one hand, resources are so limited that the typical case manager is eager to provide closure as soon as possible so as to shift resources to those on a waiting list. On the other hand, one of the understandable desires of case managers is to hold on to some of their successful cases as a respite from many frustrating cases. This is related in part to a desire to maintain morale in the face of inevitable failures. On some occasions case managers will have to accept the fact that in spite of all they do, they will not be successful with all of their cases as some will inevitably need nursing home placement.

Maintaining Relationships Following Closure

The majority of case management agencies maintain telephone contact with consumer's who have gone off services for a minimum of one month. Most programs regard it as a wise investment to maintain a communication link with former consumers. This kind of follow-up is to reinforce the consumer's achievements, track program results and keep access open to old and new consumers when adverse changes occur.

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overhead -- purpose of ongoing communication

Specific purposes for ongoing communication after case termination or closure include:

- keeping the door open for former consumers whenever the case-management service is needed again;
- facilitating the referral by former clients of new clients;
- providing feedback to staff regarding consumer progress (for staff morale) and extending a gesture of continuing interest and friendliness on behalf of workers;
- providing ongoing moral support to consumers (they do not need to get worse to get attention)

as an intervention with its own value to the consumer;

- supporting the ongoing service provider, if any, by recognizing the value of their continuing service to the consumer and showing the programs' readiness to assist when necessary;
- ensure the earliest possible alert to consumers' pending discharge from a hospital or nursing home for which case management may be needed; and
- giving "drop-out" or service-rejecting consumers a second chance. (Some older persons refuse service for fear that control of their lives will be taken out of their hands. After they have tested the agency's acceptance of their right to refuse, many will accept service when a second opportunity is offered.

Methods for Maintaining Contacts

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overhead -- methods for maintaining contacts with consumers

The case management agency needs to allocate a limited amount of resources to maintaining relationships with former consumers. Even in the presence of a waiting list for case management services, benefits can accrue for the agency that chooses to cultivate relationships when services are stopped. Some of the methods for follow-up include:

- referring consumer, before closure, to ongoing programs of telephone reassurance or friendly visiting whose workers are aware of the case management program should the need arise at a later time;
- routine mailings of greetings at a holiday season or on the consumer's birthday or on the anniversary of leaving the program;
- routine offering of a short-term service, for former as well as current consumers such as assistance with annual tax forms or senior discount identification cards;
- periodic consumer satisfaction surveys or evaluation studies of consumer status;

Closure involves soliciting information from the consumer with respect to their satisfaction with the case management agency's service. This type of information is vital input for the agency to maintain its direction. Also ask

if they believed that they were part of developing their care plan. Practicing case managers believe that certain benefits accrue in maintaining a log of dispositions. Such a log is not an indicator of success, but helps the case manager to have a better picture of the profile of their consumer base, for example the percentages of closures by death, through improvement and what was their basic health condition. In addition, this helps the case manager to understand the effectiveness of the interventions offered. This is one component of performance evaluation of the case management agency. Keep percentages of deaths, closures through improvements, etc.

TOPIC

E. PROGRAM EVALUATION

OBJECTIVES

1. The participant will gain an understanding of the need for evaluation of their programs.
2. The participant will gain an understanding of evaluation and quality assurance.
3. The participant will gain insight into the components of a *program evaluation* approach.
4. The participant will gain insight into the components of *quality assurance.*
5. The participant will gain insight into how to blend *program evaluation* and *quality assurance.*
6. The participant will gain an understanding of the principles for conducting *program evaluation* and *quality assurance.*
7. The participant will gain insight into the need for a new evaluation model.
8. The participant will gain insight into the importance of a positive service interaction.
9. The participant will gain an understanding of the background of *Total Quality Management* and *Continuous Quality Impovement.*

10. The participant will be exposed to Deming's *Fourteen Points* and *Seven Deadly Diseases*.
11. The participant will gain an understanding of the key principles of *continuous quality improvement*.
12. The participant will gain an understanding of the differences between *quality assurance* and *continuous quality improvement*.

Rationale for Program Evaluation

Winston Churchill said, "the farther back one can see, the farther forward one can see." While Churchill's remarks are generally used with respect to the importance of reflecting on life's accomplishments and pleasant memories and that those exist in sufficient supply to carry one forward during times when the course is uncertain, Churchill's remarks also have implications of importance for the case manager to pause and evaluate their work, and in so doing, keep their efforts on the right course.

Despite the increase in the provision of case management, limited information has been made available with respect as how to best monitor and evaluate the effectiveness of the case management program. The following information is offered as suggestions that might trigger the case manager into adopting portions of what is offered or devising their own procedure. It is crucial that the beginning case manager understand that in some cases they have no choice, as many funding sources require evaluation usually using predetermined procedures and criteria.

There are several important reasons for conducting an evaluation of the agency's program including:

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overhead -- reasons for conducting evaluation of program

- the need to comply with agency regulators (while not the best reason, it may realistically provide the highest motivation)
- the need to demonstrate agency accomplishments and effectiveness to funding sources
- the need to improve the practice of agency personnel including:
  - methods of allocating services,

- more accurate targeting of consumers and
- enhanced supervision of case managers

Improving agency practice is the most compelling reason to conduct evaluation activities. Practicing case mangers may often assume that their current practice is the most beneficial to consumers, when, in some cases as the result of evaluation, other methods may prove to be superior. If evaluation activities fail to provide useful information to the case management agency personnel, there is little incentive to initiate such activities. Therefore, evaluation effectiveness is essential in order to sustain the effort and provide the necessary information needed for the agency and its case managers to take corrective measures.

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overhead -- barriers to evaluation

Case management agencies are sometimes ambivalent regarding program evaluation. On the one hand they desire the information in order to demonstrate their effectiveness. On the other hand they are often concerned about the costs and other potential difficulties associated with undertaking evaluation activities. Numerous barriers can impede the case management agency's action in undertaking an evaluation of their work activities. Common barriers include:

- An expectation that there will be an increase in the paperwork burden by case managers who believe themselves overburdened with paperwork.
- Associating evaluation with a language or skills level that is not in the vocabulary of many of the agencies' personnel, such as the language of statistics such as *mean, median, mode.*
- The costliness of the evaluation activities in terms of both agency dollars and staff time.
- The resistance of service providers to evaluation based on the knowledge that their services are of high quality.
- The fact that evaluation reports are frequently not written for the case manager and seem to lack relevancy to daily practice concerns.

Evaluation and Quality Assurance

It is a premise of this training material that a major objective of case management agencies (and their case managers) is the provision of quality services to the most needy individuals in the most efficient and effective manner possible. Evidence of good quality care is provided through the combined functions of **(1) evaluation** and **(2) quality assurance** (Applebaum & Austin, 1990). Therefore, it is important to differentiate between three distinct concepts: quality, evaluation and quality assurance.

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overhead -- two determinants comprising quality care

- program evaluation
- quality assurance

Evaluation seeks to answer the basic question of whether the services that are delivered have had their intended effects. Do the individual seniors that receive a particular service do better than those not receiving such care? An example of the desired effects can be frequently seen on a variety of television commercials such as one using individuals who brush with a particular toothpaste doing better (as measured by number of cavities) than the individuals not brushing with that same brand of toothpaste. Likewise, do seniors receiving case management services do better than those who do not?

Once it has been established that a certain service or product does, indeed, result in the expected outcomes, it then becomes possible to address quality assurance. Quality assurance seeks to ascertain how this beneficial outcome can be assured across time and across a variety of settings with different case managers. Quality assurance involves two major components. First, the product or service must be operationally defined, and second, precise standards must be developed. With case management, as well as other disciplines, the development of standards is essential in order to know exactly what the service should look like and that this image should be capable of duplication. Only after the service or product is defined and the standards are established can quality be ensured. After the discipline's practice standards have been developed (in this instance, case management), the quality assurance process is used to monitor whether the service(s) delivered complies with the standards. Therefore, quality assurance coveys the notion of "compliance to standards."

Combining the evaluation (knowing the outcome of a service) and quality assurance (knowing that the service is implemented in a consistent manner) results in a comprehensive approach to ensuring high quality care. It is important that the selection of specific evaluative and quality assurance techniques must be tailored to the individual circumstances of the case management agency involved as no one best approach exists for all programs. Factors, such as size of the program, resources available, program objectives, funding source requirements and perceived effectiveness, all help to determine appropriate monitoring and evaluative strategies.

Components of Program Evaluation

Efforts to conduct program evaluation can be classified into three categories:

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overhead -- approaches to program evaluation

- *descriptive measures and indicators* that can provide a description of program components
- *program review* that provides a qualitative review of case management practice
- *program impact studies* that assess the extent to which specific outcomes have been accomplished for consumer receiving case management service

Descriptive Measures

An essential first step in evaluating any program is the creation of descriptive measures or indicators. These items provide a description of program components and serve the dual purpose as quality assurance performance indicators and as a description of the program for more extensive evaluation. Descriptive measures are straightforward to collect and measure. These measures do require some type of information system and do not provide conclusive evaluative information about program outcomes, as they are only indicators.

The purpose of descriptive measures is to clarify key elements of the case management program so that the nature of the services provided by the agency are clearly understood. Documentation of program components can be accomplished through both quantitative indicators and qualitative indicators. For example, a quantitative program indicator would be the length of time that it took to complete an assessment after a new consumer was referred to the agency. If the elapsed time, for example, from the time of referral to the completion of the assessment was three months, the agency staff might conclude that they were not implementing at an acceptable level based on the needs of the consumer population that a their program is designed to serve. An example of a qualitative approach might involve an interview with the referral sources to gain information on the adequacy of the referral process.

There are numerous indicators that agencies can use to describe and document program activities. While indicators do not address program outcomes, they can provide essential information about case management program operations. Other descriptive indicators would include the functional level of consumers, their living arrangements, how well the program follows targeting criteria, the timeliness of care plan implementation and the degree to which the care plans meet the consumers' needs. These types of items serve two primary purposes; first they serve as indicators of good practice, and second they provide the necessary foundation for other evaluative approaches. Information items such as those mentioned above have generally already been collected or are continuously being collected and are readily available. In addition, the use of these indicators does not require special training of personnel on the part of the agency.

Program Review Approach

The program review approach involves systematic review to assure quality of case management activities. Program review provides a qualitative review of case management practices, emphasizing a review of processes performed by case managers. It allows case management agencies to review the actual practices of case managers and to make judgements about quality of case management activities. Program review does not provide conclusive evaluation information about the effectiveness of program outcomes.

The way in which the program review strategy is used is that case manager activities are compared to professional program standards. Rowland and Rowland (as cited by Applebaum & Austin, p. 91) define a standard as a clear statement of an acceptable level of care that results in a desired quality end. In some agencies a program audit is used in which a sample of cases is selected for review by a panel of independent professionals. The same plan might then be asked to review the care plans of sample cases and compare these plans to the consumer assessment data. Such a review would examine to see if problems that were documented in the initial assessment were properly addressed in the care plan. Such information yields trends in a case manager's performance and can be used by those in a supervisory capacity to counsel the case manager so that corrections can be made. Examples for which corrective action could be taken would include when the review indicates that certain case managers tend not to maximize the use of the informal network or fail to address mental health or social needs.

Another example of program review activity involves either a case management supervisor or a consultant to accompany the case manager on visits, such as the initial client interview and/or the assessment. Such a strategy is helpful for new case managers by ensuring that the correct functional limitations are identified or in determining the tasks that the informal network can be counted on to perform. This strategy is also effective when a case manager has stronger skills in one area such as with identifying social needs and is not as strong with medical conditions that are very complex. In such a case, a case manager who is stronger in medical/physical conditions could assist the other and serve as a training session.

As mentioned earlier, the program review information does not provide definitive evaluative information. The approach does provide important information about the quality of the case management and can function as an important quality assurance and supervisory strategy. While the program review technique is inexpensive to implement, it does have additional limitations. One limitation is that a "paper review" comparison of assessment data and care plans may not accurately reflect the complexities of a particular case. An example of such a review is the identification by the case manager of a mental health problem that the family wants to delay until a physical condition experiences improvement. Another comparison that is difficult to make strictly from the observation of paperwork is that of cost considerations, as hidden factors might not show in the consumer's file, particularly with respect to the informal network.

Program Impact Evaluation

The program impact approach is designed to answer the question of whether the case management program affects clients as intended and/or differently than an alternative model of care. Program impact as an evaluative approach examines specific outcomes for those receiving case management services. It relies on experimental design where program consumers are compared to those of equal functional competence and not receiving services. Program impact evaluation is the most powerful way to examine a program's impact and generally the most difficult type of evaluation to implement. In general, it requires more expertise, resources and involves possibly more burden to consumers.

The program impact approach makes use of specific outcome type measures such as mortality rates, nursing home placements, hospital visits and quality of life issues. Through the use of proper evaluation design procedures, case management agencies can address the question (for example) of fundamental and ultimate importance such as, "do individuals receiving case management services function better, worse or the same as similar individuals not receiving the services?" This is the only approach of the three listed (descriptive measures, program review measures and program impact approach) that can directly address consumer outcomes.

Quality Assurance

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overhead -- approaches to quality assurance

Quality assurance has received considerable attention in the acute and long-term care institutional health arenas and in the delivery of home health services funded by Medicare. Quality assurance has received little attention in case management and community-based services. Approaches to ensuring the quality of care through the quality assurance component have generally classified into the following three categories:

- structural strategy
  - agency certification
  - individual licensure
  - training standards
  - employee relationships
  - staffing ratios (case mix ratios)
  - professional credentialing

- process strategy
- outcome strategy

Structural Strategies

Structural strategies for quality assurance analyze the organizational framework for service delivery to ensure that services are of high quality. Structural efforts to ensure quality have generally examined the agencies' capacity to provide care, looking at such items as the correct license for employees who require such, are the licenses current, do employees meet training standards and the agencies compliance with regulations at all levels. While these measures are straightforward and routinely available, they should be viewed as indicators of capacity and do not necessarily ensure quality. The structural approach is based on the notion that if providers meet the established requirements of their field that it is likely that good quality of care will be an outcome.

Structural methods have been the dominant method used to ensure quality of care. The major reason that this is the method of choice is that information is easy to collect. It is much more difficult to determine how a case manager is doing on the job compared to determining if they have certain credentials and have participated in mandatory training requirements. Structural indicators are generally viewed as important first steps, but are not sufficient to ensure that a service will be of the level of quality that the agency and its consumer desire and expect.

Process Strategies

The process strategy evaluates the way in which a particular service is provided compared to the general acceptable levels of practice. Process strategy assumes that a trained individual, with full knowledge of the prevailing standards, can observe the service being provided and make a determination whether the service is provided at an acceptable level of practice. For example, a case manager can observe a homemaker aide providing a service such as housekeeping and can make a determination if the task is performed properly.

The process approach requires that the case management agency have standards of practice in place or both desires to have and is capable of generating such standards. Process review can be accomplished through a review of records, personal observations, interviews or a combination of these methods. The limitation of this approach is that it relies on the professional wisdom of the case manager in coupling what is observed or reported with established best practices.

Outcome Strategies

The outcome approach focuses on what happens to the consumer after the service has been provided. The process approach seeks to answer the question, "is the person receiving the care maintaining or improving in the area for which the care was deemed essential for them to remain in their home?" A subset of this focus also examines if the consumer is well nourished, properly groomed, safe and whether or not the overall package of services is such that their major care needs are being met. Without strategies, the expected and desirable outcomes of service delivery must be identified so that the care received can be reviewed according to the established standards.

The major strength of the outcome approach is the provision of direct information about the consumer's condition. The outcome approach is far superior to either the structural approach and/or the process strategy, as the latter two serve as precursors to quality assurance. Outcome based measures can also have limitations. First, the actual outcome for a particular service can often be difficult to quantify through definition or measurement. Consumer judgment of service quality can be particularly difficult to operationalize, especially when the individual is frail. Collecting and recording this type of information can also require considerable effort. A second limitation has to do with the methodology traditionally used under the outcome approach. Outcome methods generally focus on the individual consumer or groups of consumers without the benefit of experimental design used in impact evaluation. Therefore, it can be difficult using the outcome approach to distinguish between the negative effects resulting from poor quality service and possible deterioration of the consumer being served. This is a particularly prevalent problem in providing services to persons with long-term care needs.

In summary, practicing case managers report that unscheduled visits in which they observe a service being delivered is a good indicator of the quality of the service being provided. If at this visit any particular component of care appears inadequate, including consumer satisfaction, then a more in depth analysis of quality assurance is implemented that incorporates ideas from the three approaches of structural, process and outcome strategies. Additional examples of findings that might trigger the need for further investigation include a consumer's declining physical functioning or an abnormal number of hospital admissions. It is recommended that the case manager establish their own procedure that reflects a balance of the ideas from the three approaches. Incorporating outcome based measures into case management and community-based services is new, yet it is a vital component of a balanced approach to quality assurance.

Blending Program Evaluation and Quality Assurance

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overhead -- blending program evaluation and quality assurance

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This section began by saying that a comprehensive approach to ensuring high quality of care involved merging the functions of **evaluation** and **quality assurance**. The individual functions each have important merits, yet merging the functions or borrowing concepts from each leads to a superior approach to the evaluation of case management activities. Quality assurance tends to focus on structural measures (e.g. employees meeting training requirements) to ensure that services are of high quality. Process review is a component of both evaluation and quality assurance, yet it has been a more common technique of quality assurance. Outcome strategies are also used in both areas, yet practicing case managers seldom utilize the scientific process which would mandate the use of a control group. This type of data seems to be gathered only for those requiring a hospital visit.

Comparing program evaluation and quality assurance suggests that in many instances elements are interchangeable. For instance, a descriptive evaluation component--such as the length of time taken to provide services--could also be defined as an element of a quality assurance system. Although there are some differences between program evaluation and quality assurance concepts and terminology, it is generally agreed that the key elements of both must be combined as part of an agency's strategy for providing quality services.

Principles for Conducting Program Evaluation and Quality Assurance

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overhead -- principles of program evaluation & quality assurance

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Program activities, monitoring and evaluation activities are the responsibility of the case management agency. The use of an outside consultant to perform these tasks is permissible, however the responsibility for these activities ultimately rests with the agency. The following principles are recommended (Applebaum & Austin, 1990, p.84):

- The case management agency must link its planning, administrative and evaluation practices together. Evaluation efforts cannot be a separate activity within the agency; rather they must be an integral part of program administration. In order for monitoring and evaluation activities to be meaningful, the agency must carefully examine the collected data and use it to the best advantage to ensure quality of services. For example, developing a recording process to examine the length of time it takes for the agency to provide services to the client following intake is important information only when it is shared and used in a manner that is constructive.

- An individual or individuals within the agency should have the primary responsibility for the planning and evaluation process. Responsibility is one of the key concepts of this model. Case management agency staff need to maintain overall responsibility for the evaluation process. Practicing case managers generally believe that a common problem is that case managers often fail to appreciate the evaluation component because the information generated is never shared with them or corrective recommendation implemented. These are internal concerns and not the responsibility of an outside consultant. The agency might use a consultant to inaugurate the process.

- In order to design a strong model of planning and evaluation, the agency should involve a broad range of participants. The chances that an evaluation approach is going to be adopted will be increased if the process is developed by agency personnel. This has the effect of assisting employees in "buying" into the effectiveness and importance of the process. These are the key individuals who are ultimately going to be involved in collecting and utilizing evaluation information.

- The agency's administrative staff must have a strong commitment to the evaluation process. This is evidenced by the amount of resources allocated to the evaluation efforts and the degree to which the information generated is ultimately fed-back to employees. Examining the planning, administrative and evaluation needs of a case management agency is a major undertaking. This includes both economic costs and staff time, since staff time is needed in the gathering and analysis of the data. Developing and implementing a comprehensive planning, evaluation and monitoring strategy requires a major initial investment and an ongoing maintenance effort. The administration of an agency is responsible for setting and maintaining the standard of an agency, and if these individuals lack sufficient commitment to the evaluation process, little serious activity will occur.

Additional Evaluation Criteria

Practicing case managers report the use of many other methods and criteria in the evaluation process. This training material believes that some are worthy of mention. The first important consideration focuses on the agency's adherence to entrance criteria. On the one hand, the case management agency must make the determination that the senior seeking services has conditions that are valid and of the magnitude that scarce resources can be extended, regardless of the time anticipated duration. On the other hand, are the service needs so excessive that regardless of the services that the case manager can package and implement, the consumer's ability to remain in their home or leave a hospital for the home are questionable and problematic? Although most case management programs screen consumers at entry, a final eligibility determination is performed by the case manager.

Here, case managers serve in a dual role as consumer advocates and as system gatekeepers. The evaluation question from a quality assurance perspective seeks to answer the question of how well the established criteria for program eligibility is being followed.

Since consumers are deemed eligible based on an assessment, the concern involves the degree of accuracy of the assessment in reflecting the consumer's status. The possibility exists for case managers, in an advocacy role, to record the characteristics consumers need to become eligible for the case management program. When such an instance occurs, a problem develops with the validity of the data. The best counter measure is to have a second interview/assessment occasionally by a second case manager. The best of intentions on the part of the case manager can, in the case of consumers from either extreme, generate a negative impact on the resources expended by the agency.

A second additional criteria that is related to consumer outcome is that of consumer satisfaction. Generally this information is gathered with the use of a brief survey instrument at the time services are terminated. The survey approach is a direct method in which consumers are asked about case management services received. While this procedure does not involve the use of a comparison group, it provides important descriptive information and serves as an indication of how consumers perceive the quality of the services they received. The case manager should observe for trends in the results. For example, if low satisfaction is consistently reported, this could suggest that a particular problem should be investigated.

The major difficulty with the survey process, whether by return form or telephone, is that there is no comparison group. Practicing case managers believe that it is a good practice to obtain similar information from family members or that they should assist the senior in completing the survey questionnaire. The survey is open to other limitations such as consumers being hesitant to report problems in fear that the agency will not admit them should they need the service again. Other important sources of information could originate from consumers who withdraw on their own. The case manager needs to examine these results to ascertain if the withdrawal was from dissatisfaction, inappropriate packaging or that the services were no longer needed.

Additional considerations include the fact that funding sources require some form of fiscal evaluation. In the aging network, case management services agree via a contract that for a given funding cycle, which includes a predetermined level of funding, they will provide services for a predetermined number of consumers. Therefore the funding agency examines to see if the agencies' projections were accurate, such as the number of consumers served are within the funding level as set forth for the contracted period. The case management agency gathers and maintains financial information so that it can determine the precise amount of dollars needed per consumer per year.

Monitoring agencies that provide funding sometimes fail to obtain adequate financial information so as to evaluate the effectiveness of case management services. A more accurate picture would compare or contrast Medicare dollars expended in an institutional setting with Medicare dollars expended for in-home services under the same conditions. Likewise, institutional services covered by Medicaid should be compared with services covered by the same source for community-based care. Only through a compilation of dollars from various sources can actual comparisons be made.

The difficulty is trying to determine the extent to which case management dollars forestall nursing home placement. Some case management consumers might have managed on their own or with someone to organize the informal network. Practicing case managers do have evidence that hospital discharges are sooner (fewer days in hospital with each admittance) when the case manager is included in all of the hospital planning process and can provide important services at discharge. The cost of care for consumers utilizing case managers when the consumer enters the hospital and being able to be discharged directly to the home, should be contrasted with hospitalization and no case management for the same condition (diagnostic related group). Is the time of hospital stay longer for those without case management, in addition to the need to recuperate in a step-down unit or nursing home before returning to home which is generally about three times as expensive as the community based services directed by the case manager? These types of statistics resulting from in-house evaluations are well-received by legislators when funding cycles come under close scrutiny. Such figures on documented studies in Texas strengthen the cause of case management services. Case managers, using such strategies, strengthen the case for cost sharing by showing that the family (informal network), Medicare (federal source) and Title III sources working in tandem serve to reduce the total expenditures on any one source.

The future for case managers is sure to involve a closer examination of dollars expended, and as computer information networks become more sophisticated, it will become increasingly more important that funds expended from all sources be examined for each consumer served. One problem that exists at the state level as various agencies make their case with the legislature is that the Texas Department of Human Services makes a strong plea with the legislature to prove that their in-home services are keeping consumers out of nursing homes, and with good cause; yet there is a growing number of seniors whose income is just above Medicaid guidelines. This number is getting larger every year, and this poses a pressing concern for case managers working with Title III funding who are committed to keeping persons in their homes. Needs are not a function of financial status, yet Medicaid- qualified consumers tend to get more services than those with marginal incomes who fail to qualify for Medicaid because Medicaid is better funded than Title III.

The standards for community-based services are such that the provider is given more latitude than those providing institutional services. The case manager has less red-tape and is working in a system that is designed to respond quickly to changing conditions. This is good from an evaluation perspective, as the care plan can be changed as needed to reflect changing conditions. Thus, there is less of a chance that an adversarial relationship will develop between the funding source and the provider.

Rationale for a New Model for Evaluation

From the beginning of Module I to the end of Module III, this material has sought to place the recipient of case management services (the consumer) at the center point. Being at the center point, the consumer and/or their family is an integral (essential to the entire process) component in the case management process. They are asked to supply information, both with respect to their goals with services and as to their functional nature; they assist with the development of the care plan and are expected to offer information regarding the appropriateness of the package of services that they helped put in place. While the authors are not trying to be repetitious, the position of the recipient of services as an equal partner is in sharp contrast to the relationship between the typical patient and physician that is found in the acute care environment. Physicians and clients are not viewed as equals in a partnership because the power of knowledge is held by the physician to bestow upon the client in order to facilitate healing. The physician's role is sustained because of the passive nature of the recipient in an acute care environment. All helping professions have inherited this legacy to some extent, and case managers who may find themselves caught in this role working with older consumers need to change the playing field to one in which the consumer is an equal partner in the case management process.

With the rapid growth in community-based programs targeting the frail elderly, case managers are increasingly more anxious to have mechanisms in place to ensure quality in the services they package. Practicing case managers generally believe that a medically based, institutional biased regulatory model, borrowed from hospital and nursing home regulations is not the answer to the evaluation of their programs and services. In-home services are very different and perhaps require a different evaluation to assure quality. According to one leading source (Kane, Illston, Hixon, & Kane, 1990), many of the issues in the delivery of community-based services can be traced back to the fact that the site of care is on the consumer's territory rather than the provider's. Consequently, there are several basic differences, with respect to ensuring quality, between institutional care and home or community-based care. Kane et al. (1990, p.14) give the following list of differences.

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overhead -- difference between institutional care & home care-QA

- **Lack of Provider Control** - In an institutional setting, providers can set professional standards for sanitation, efficiency and routine. Community-based care happens on the consumer's "turf" and should be responsive to the consumer's preferences and routine.
- **Private Homes as Care Environments** - Private homes are not designed for service delivery and few meet the physical standards of an institution. Providers need to be flexible and creative in the way they manage services.

- **Family Involvement** - Family members usually participate in the delivery of home care. They have a voice in what services they provide and how they provide them, which complicates regulatory (and thus evaluative) efforts.
- **Intermittent Service** - Unless 24-hour care is provided, home care is often intermittent. Providers cannot control what happens between visits.
- **Worker Isolation and Lack of Immediate, Onsite Supervision** - In-home workers are isolated from their peers and, unlike institutional providers, are not monitored by onsite supervisors.
- **A Shared Responsibility for Quality of Life and Risk-Taking** - In an institution, the care provider sets certain standards to minimize risk. In a home care environment, "quality" (as defined by the consumer) may mean that the consumer will wish to take risks. For example, one participant may choose to remain in his home, even though that home is in a dangerous neighborhood; another may choose not to receive an Emergency Medical Response System, even though that service is recommended. In home care, the consumer has the right to assume responsibility for risk-taking.

These differences present a challenge to quality that regulation cannot address. Standards and regulations typically target themselves at things such as the physical quality of the care environment, the extent and quality of supervision and the institutional control over and responsibility for the quality of life. These are issues over which the home and community-based care system has no, less or very limited control. In fact, the amount of system control is circumscribed by the consumer's right to privacy.

The essential character of the service transaction in community-based care seems to defy regulation. Like anyone else, long-term care consumers have the right to determine what they do in and with their own home environment. Services are expected to be individualized to respond to consumers' differing needs, values and preferences.

Personnel with community-based providers are expected to provide appropriate services, accommodate consumer personalities and maximize "caring moments." In-home care is highly personal and each consumer has his or her own definition of "quality service" and "quality of life." The challenge becomes being able to assess, in some standardized way, how well individualized services are achieving goals that can be both intangible as well as tangible and assess the extent to which the service delivery system helps or hinders that achievement.

Placing a Priority on Service Interaction

How a service is provided becomes as important as what is provided. Moments of contact between the direct care providers and recipients of care are the central service transactions that contribute to a sense of service quality. These potentially intimate and personal moments of direct contact must be managed so as to achieve quality in the delivery of services:

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overhead -- outcomes of quality -----

- A rich and trusting relationship between the case manager and other care provider and the consumer;
- The consumer both is and feels fully empowered to make choices about the nature and quality of the care, and
- Enables services to be uniquely tailored to me et the health and social care needs of the consumer.

The concept of ***character in the caring moments*** implies services should provide more than superficial or momentary "delight." The time of service delivery should address the deep and rich issues central to the quality of a person's life and should achieve the core program values and goals. **Caring** describes the service transaction and conveys that services should be delivered in a respectful, empowering and "caring" way. The moment of service delivery provides the opportunity to make a difference -- to please or delight the consumer. Further, caring moments embodying the character of quality do not just "happen"; neither are they completely dependent on the character or personality of the service provider. These moments must be managed and supported by a service system that is set up and operated to ensure and improve their quality.

Total Quality Management & Continuous Quality Improvement

In search of strategies and techniques to more effectively evaluate and at the same time ensure the viability of quality improvement in community-based services, providers are turning to approaches that have proven to be successful in business and industry. In the delivery of community-based services, just as with the production of goods, it is important to access program effectiveness with the components of Program Evaluation (descriptive measures, program review and program impact), in conjunction with the components of Quality Assurance (structural strategies, process strategies and outcome strategies). Unfortunately figures on productivity, whether in the delivery of community-based services or the production of goods, do not also help to improve quality. Measures of productivity frequently are like statistics on accidents; they tell you all about the number of accidents in the home, on the road and at the work place, but they do not tell you how to reduce the frequency of accidents.

The following comments are offered on ***Total Quality Management*** as it offers a currently well-accepted approach to management and assurance of quality. Total Quality Management (TQM), also known at ***Continuous Quality Improvement*** (CQI), was popularized by W. Edwards Deming. It is generally accepted that either TQM or CQI eventually will be the accepted approach to the production of all goods and food, but also the service industries as well, such as hotels, restaurants, transportation of freight and passengers, wholesale and retail establishments, hospitals, medical service and all programs involved in caring for this nation's elderly.

A brief word is offered about Mr. Deming. Mr. Deming was born in 1900 in Sioux City, Iowa; and moved as a child with his family to Cody, Wyoming, then later to Powell (same state). Deming received his bachelors degree from the University of Wyoming, master's degree for the University of Colorado and a doctorate of philosophy from Yale University with a concentration in physics. He was employed by Western Electric at their Hawthorne plant in Chicago at the time Elton Mayo conducted his research on the relationship between working conditions and productivity. Some of his ideas on management and quality are rooted in his experience at the Hawthorne plant.

In 1927, Dr. Deming went to work for the United States Department of Agriculture, which was conducting pioneering efforts in the use of nitrogen and a food crop. Using statistical procedures developed for the Department of Agriculture, he devised a means by which workers could chart their own work, and thus make their own adjustments. By exercising control over their own work environment through this charting process, the productivity of the agricultural department in the areas of research were greatly enhanced. Later he developed the sampling procedures used by the Commerce Department in the census process. Deming's, as a statistician, lifelong mission became the seeking of sources of improvement production quality. He realized that statistical procedures were not enough to ensure quality and concluded that what was needed was a bedrock philosophy of management that was consistent with statistical methods.

In 1946, Deming left the Census Bureau to establish a private business. He also served as a faculty member of New York University in the Graduate School of Business Administration, where he taught quality control. In 1947, Deming was recruited by the Supreme Command for the Allied Powers to help prepare for the 1951 Japanese Census. When he arrived in Japan, little recovery from the devastation of the World War II had occurred. He was very touched by the miserable conditions being experienced by the Japanese people, particularly by the hunger experienced by the children.

Dr. Deming, because of his benevolence in helping with food supplies, was invited by a group of Japanese scientists and engineers to assist them in the reconstruction of their country. Night after night Deming would meet with this group. It was clear to Deming that Japan had to export goods for money to buy food, yet at that point in time, anything marked. "Made in Japan" was synonymous with junk. The rest is history, as the Japanese incorporated Deming's ideas, their products grew in demand the world over. The underlying reason for the demand of their products was they represented quality. The quality found in Japanese products can be traced to the "Fourteen Points" that Deming formulated and taught the Japanese in the early 1950s.

Deming's Fourteen Points and Seven Deadly Diseases

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overhead -- Fourteen Points

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1. *Create constancy of purpose for improvement of product and service.* Use innovation, research, constant improvement and maintenance, rather than just to make money. Case managers must be consistent and are frequently called upon to be innovative in the design of services or motivation of the informal network. A key element is placing the consumer at the focal point and remembering that it is their needs that give the agency a reason to exist. They are the most important ingredient in the equation, requiring that the case manager be consistent in knowing them very well. It is through knowing the consumer that effective packaging of services (meeting service gaps and cost effectiveness) can occur.

2. *Adopt the new philosophy* (strive for perfection). Americans are too tolerant of poor workmanship and sullen service. Deming believed and taught that mistakes and negativism are unacceptable. Case managers need to take pride in their work and through continued monitoring adjust the care plan to meet changing consumer needs.

3. *Cease dependence on mass inspection.* With respect to industrial production, Americans typically inspect a product as it comes off the line or at major stages. Defective products are either thrown out or reworked; both are very expensive. Quality comes not from inspection but from the improvement of the process. Through training, workers can be enlisted in this improvement. Case managers need to constantly strive for ways to improve the process of the delivery of community-based services.

4. *End the practice of awarding business on price tag alone.* This has implications for community-based services as case managers are called on to maximize the use of scarce resources, yet they must seek the best quality and work to achieve the desired outcome for the consumer. Inefficiency in the human services, just as in the production of goods, raises prices.

5. *Improve constantly and forever the system of production and service.* The key point here is that improvement is not a one-time effort. **Quality is not static**, thus change is inevitable. Case managers are obligated to continually look for ways to reduce services not needed and improve the quality of services that are in place.

6. *Institute training.* Too often personnel have learned their job from another worker who was never trained properly. They are forced to follow unintelligible instructions. They fail to do their jobs because no one has ever instructed them on how to do their jobs. A good example of an area case managers need to observe skill levels and where training is often needed is in the area of personal care such as bathing or lifting.

7. *Institute leadership.* The role of a supervisor is not to tell employees what to do or to punish them but to lead. Leading consists of helping people do a better job and of learning by objective methods who is in need of individual help.

8. *Drive out fear.* Many employees are afraid to ak questions or to take a position, even when they do not understand what the job is or what is right or wrong. Employees will continue to do things the wrong way, or to not do them at all. The economic loss from fear is appalling. It is necessary for better quality that people feel secure. Quality, according to Deming, results when any employee can take pride in their work. A frequent fear related problem in the human service arena surfaces as providers are sometimes reluctant to discuss new problems experienced by consumers. Dr. Deming believed that a fundamental problem in any business is that workers are scared to discuss the problems of people. This could also include inter-agency personnel, personnel of other providers or members of the informal network.

9. *Breakdown barriers between staff areas.* Often staff areas -- departments, units, etc.-- are competing with each other or have goals that conflict. They do not work as a team so they can solve or foresee problems. This criteria has implications both for inter-agency functioning and between case managers and other service providers.

10. *Eliminate slogans and targets for the workforce.* Let employees develop their own slogans.

11. *Eliminate numerical quotas.* Quotas take account only of numbers, not quality or methods. They are usually a guarantee of inefficiency and high cost. Under such circumstances an employee will meet a quota at any cost, without regard of harm to the agency or potentially the consumer.

12. *Remove barriers to pride of workmanship.* People are eager to do a good job, particularly in the human services and are generally distressed when they cannot. Case managers need to observe for barriers that impede the delivery of the services they put in place. Frequently personnel do not know what is expected of them. Higher quality will result when these barriers are removed.

13. *Institute a vigorous program of education and retraining.* Human service programs require that training be ongoing. This is a key to ensuring quality of care, particularly with community-based programs.

14. *Take action to accomplish the transformation.* A transformation to a new philosophy using these steps must be incorporated at all levels of service delivery. Managers cannot do this by themselves nor can those at lower levels acting alone; everyone must be involved, as a critical mass of people in the agency must understand these points.
(Walton, 1986, p. 34-36).

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overhead -- Seven Deadly Diseases

Dr. Deming, likewise, had deep-seated beliefs that common themes existed in the delivery of goods and services and that these needed to be lifted so as to ensure quality. He referred to these major problems as the:

The Seven Deadly Diseases

1. *Lack of constancy of purpose.* Consistency of purpose was the first of the 14 points, in its absence a company or agency cannot survive. In the area of human services, a mission statement can act as a giant hand

by which the entire agency is guided; assuming that the mission statement is instilled in all employees. Once a mission statement is formulated, it is management's task to make sure that it becomes a "living" document. Everyone in the organization must understand it and must integrate it into their day-to-day behavior. There must be consistency between what the mission statement says and what the agency actually does. Management must provide the leadership and must act as a role model in this endeavor. It must be open to feedback which points out any discrepancies between its behavior and the mission statement. For this positive interchange to take place the case manager has to communicate the desire to know when his or her behavior is at odds with the mission statement. Such an attitude will encourage open expression of concerns on the part of other service providers. The case managers must act on any and all information they receive, otherwise providers and family members will begin to feel that they are wasting their time because of the lack of interest in their feedback. Practicing case managers report that a good practice is to periodically review the significance of the mission statement with new employees.

2. *Emphasis on short-term results*. Many conditions faced by the disabled elderly require long-term planning as chronic conditions by their very nature do not have a cure. The case manager is cautioned not to create dependency.

3. *Evaluation by performance, merit rating or annual review of performance*. Performance evaluations encourage short-term performance at the expense of long-term planning. It is the long-term planning that is critical to case management and the ability to change as consumer circumstances dictate.

4. *Mobility of management*. People at all levels require time to learn to work together. Mobility of top agency management will put emphasis on short term results and this can be devastating for community-based services.

5. *Running a company/agency on visible figures alone*. Agencies have payrolls to meet, office space to pay for

and all the expenses that go with running a business. On the other hand, many of the services that a case manager provides are difficult to assign with a quantifiable figure; e.g., security in the home or the consumer knowing that they can remain in their home.

6. *Excessive medical costs.* Deming, in this instance is referring to the costs to the company/agency for employee illness. For providers of human services, the phenomenon of burn-out can be costly.
7. *Excessive costs of warranty.* This has application in the production of goods. However, the case manager is cautioned here to remember not to promise more than they can deliver, particularly at the time of assessment. Case managers should tell the consumer during assessment that just because they have a functional deficit, there is no assurance that the precise service gap can be filled. No one can guess the loss of business to an agency when a consumer is dissatisfied. A dissatisfied consumer might not complain; however, they will not recommend the same services to their friends.
(Walton, 1986, p. 89-93).

Principles of Continuous Quality Improvement

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show video *Continuous Quality Improvement in Long-Term Care.* Instruct class that this video, as have some others, is directed to providers employed in institutional settings; however it emphasizes the main points of CQI as set forth by Deming. Video takes 23 minutes

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overhead -- key points of continuous quality improvement

Total Quality Management (TQM), also known as (CQI), popularized by Dr. Deming has been highly effective in business and industry at increasing productivity, increasing quality and keeping costs down. Despite its origins in business, manufacturing and industry, the continuous quality improvement approach seems conceptually well suited to a highly individualized consumer oriented service such as case management and community-based services. This philosophy seems to be consistent with the delivery of human service and offers a method of pursing quality. The primary points of CQI are:

- It focuses on the system, recognizing that any one part affects and influences all others.
- It stresses that a quality process will result in quality outcomes.
- It expects active involvement from every level of the system.
- It involves all the actors as a team, each with different responsibilities for quality improvement.
- It focuses on the management of systems as well as product outcomes.
- It expects decisions to be made based on data and recognizes variation in all processes.
- It has demonstrated that improved quality results in increased productivity with decreased cost, concluding that quality improvement is cost effective.
- It is devoted to meeting and exceeding customers' needs and expectations, with consumer defined as any user in the system.

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overhead -- key principles of continuous quality improvement

- *Consumer Focus* - Quality services will meet or exceed the expectation of its consumers, with consumers being defined as any user or stakeholder in the system. This is the driving principle behind the approach.
- *Process Focus* - All work occurs as a process. It is a result of inputs from suppliers (referral sources) and outputs (service packages) to consumers. Studying how a process works and analyzing various influences on the process and their effects helps identify problems in the process. This approach would look at inadequate quality of care, not as a problem to be monitored, but as a process that needs to be

improved. A quality process will result in quality outcomes.

- *System Focus* - A system is a series of interacting processes that needs to be managed. Improving the system will produce better outcomes.
- *Teamwork* - All stakeholders (participants, i.e., consumer, informal and formal networks) with different functions in the process participate in the problem solving effort that improves the system. For example: A Continuous Quality Improvement project team to improve case management may include a consumer, a case manager, an aide, a provider agency representative and a supervisor.
- *Data Based Decision Making* - This approach expects decisions to be made based on data, not hunches; the scientific method issued to identif y root causes before developing solutions.
- *Continuous Improvement* - Pursuing quality is an ongoing process achieved by small incremental steps. There is no final end goal except meeting or exceeding the consumer's expectations, which can always be improved upon.

Contrasting Quality Assurance and Continuous Quality Improvement

Quality assurance has come to be used to refer to compliance with minimum standards. Experts set a "reasonable" standard, the provider is expected to comply, inspection occurs, sanctions are issued. **Continuous Quality Improvement** uses a process whereby a team of people involved in the process develops ways to improve a service to meet or exceed the expectations of its **consumers**. The team analyzes the service process using a variety of **data** generating techniques. The data collected helps to focus on a specific area for improvement. Solutions are developed to improve the process. The team plans improvements, tests them out, checks with consumers to determine that the changes are actual improvements and makes any revisions before finalizing its actions. The differences between the approaches may be characterized as follows:

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overhead -- contrasting quality assurance and continuous quality improvement

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QA Focuses on	QI Focuses on
Achieving a Set Standard	Continuous Improvement
Problem Inspection at End of Process	Problem Prevention
What Happened/What Went Wrong	How it Happened
External Audit by Inspector	Internal Review by Team
Meeting Predefined Standards Results	Quality Process Yielding Quality

To illustrate the difference, note the following example:

> If a personal care attendant was consistently late, a quality assurance approach would cite the provider for poor performance of its staff (assuming being on time was some standard). The CQI approach would want to look at the processes in place that might contribute to that problem, such as the processes of hiring, of selecting, of matching, of training and of instructing. The cause of the problem might be in any one of them.

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overhead -- recommendations about continuous quality improvement

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The following general recommendations about continuous quality improvement efforts are given as a result of input form practicing case managers.

- Ask consumer about what quality means to them (always)
- Define worker tasks based on detailed consumer choices about what is done, how and when. It may not be a new service that the consumer wants (or needs), but an existing service performed in a particular way. Stress "pleasing the consumer" as a fundamental job expectation.
- Empower consumers. Allow consumers a real choice versus imposing case manager or worker values and preferences. Allow them to choose their home care worker, if possible. Invite them to determine how they prefer the care or chore

be done or what qualities are important in their workers.

- Promote continuity of consumer/provider relationships. All things being equal, strive to assign fewer workers rather than multiple workers to serve a program participant. Work to reduce"turnover" of workers experienced by participants, but not at the expense of consumer choice. Establish procedures to improve matches between workers and consumers. Respect the bonds that develop between those delivering the service and the consumer, as these becoming very important.
- Help in-home workers appreciate the importance of their role and the value of their work in a consumer's life. Case managers or social service agencies may need to become more involved here. Teach and encourage workers to help consumers identify ways the quality of their lives could be enhanced.
- Encourage workers to become problem-solvers and partners in the consumer's care plan. Provide orientation, training and other support to accomplish this. Clarify and communicate expectations. Define tasks clearly. Establish mechanisms for managers to obtain ongoing feedback from workers.
- Take time for continuous quality improvement. Despite workload pressures and other barriers, taking time to improve service quality is important.

Class Activity

Divide class into groups of four. Use the accompanying instrument in which a zero (0) implies total inadequacy and at the other extreme a four (4) reflects total satisfaction. Have each member in the group be interviewed by each of the remaining three members. Each participant will then have three completed forms. After the interviews have participants average the scores on each item. This will give participants some notion of how

individual cases combine to give a more global evaluation summary of the agency's activities. Have participants then write a brief summary of how they view the performance of their agency's (imaginary) activities, incorporating the averages of the scores on the 13 item questionnaire. The summary should tell how this information will be used in developing an agency improvement plan to better serve frail elderly consumers. Ask participants to share their findings with the class.

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TENDENCIES WHEN CASE MANAGEMENT AGENCY IS A SERVICE PROVIDER

- **Case managers can develop a bias in favor of using those services rather than tailoring the care plan to the individual client ("You need --we have" logic).**
- **When a case management agency must monitor the quality and quantity of other agencies' service delivery, its own services must be beyond reproach or else program monitoring authority will be weakened and case advocacy will be compromised ("People in glass houses---").**
- **When an agency has limited resources and carries both coordinating functions and direct service functions, the direct service demands for time and resources prevail over the needs of the case management program ("Daily routine displaces planning").**

CASE MANAGEMENT IN COMMUNITIES WITH INADEQUATE RESOURCES

- **The case management program can help to obtain more appropriate utilization of what does exist, including institutions, and thus improve options for frail seniors.**

- **An effective case-management program assists in documenting service gaps and in developing new, needed services.**

- **Can function in a planning capacity by offering assistance with helping the senior understand their needs and how to utilize services in community such as meals-on-wheels, offer moral support and strengthen families through the coordination of informal services.**

CASE MANAGER TASKS WITH FAMILY/INFORMAL NETWORK

- Giving information about services to come
- Modeling behaviors in how to secure services
- Providing support or sharing responsibility for obtaining services
- Counseling or understanding problems, seeking solutions, carrying out plans for change, evaluating changes
- Helping out with a specific task or doing it for the consumer
- Confronting the consumer with how he/she may be exacerbating own problem
- Preparing for reductions or termination of services

CASE MANAGER TASKS WITH SERVICE PROVIDERS/FORMAL NETWORK

- Informing agencies about the case manager's work with the consumer
- Purchasing services (if provided in care plan)
- Encouraging providers
- Monitoring the delivery of service
- Mediating conflicts between providers or between consumer and provider
- Becoming an advocate or ombudsman when necessary to obtain or correct a service
- Correcting resource files (or service directory) to reflect actual performance of providers
- Creating new service for a consumer or class of consumers
- Identifying/reporting barriers to service delivery
- Troubleshooting arrangements with landlords, utility companies, tax officials, etc.

CASE MANAGER TASKS WITHIN THE CASE MANAGMENT AGENCY RELATED TO IMPLEMENTATION

- **Informing ancillary personnel as needed**
- **Reporting barriers created by agency policy or procedures**
- **Making and updating reports essential for case records, administration or evaluation**
- **Obtaining consultation if needed**

IMPLEMENTATION PHASE AND SHARING CONFIDENTIAL INFORMATION

- Consent form gives case manager legal protection to share certain components of confidential information
- Sharing is the only way that providers obtain a true profile of the consumer's need(s)
- Only share information with a provider relevant to the need category they are addressing
- Keep family informed
- Keep physician/physician's nurse informed
- Team members must share a common value of respect for confidentiality of information
- Written agreements with other providers' employees serve to reinforce confidentiality

SOURCES OF CONFLICT DURING IMPLEMENTATION PHASE

- Personality differences with other providers (this is minimal)
- Needed services not available
- Documentation inadquate
- Logistics
- The best of plans can fail to keep consumer in their home
- Consumer requests a service/care plan call for a service and at implementation consumer will not accept.
- Consumer fails to comply with care plan--usually as a result of dementia
- Duplication of services

SUMMARY OF IMPLEMENTATION PHASE

- Implementation is the action phase of case management that requires taking risks
- Serves to ensure efficient utilization of services
- Case management with limited services, or without services exceeds no case management
- Includes tasks with the informal network, formal network and within the agency
- Involves sharing confidential information
- Can be a source of conflict
- Usually the most enjoyable and gratifying phase of the case management experience

MONITORING DEFINED

- Monitoring is continued contact by the case manager to ensure that services are provided in accordance with the care plan and includes ascertaining whether these services continue to meet the client's needs.

- Monitoring activities, as set forth by the Texas Department on Aging (1991), include:

  performing necessary activities to ascertain the delivery of planned services and whether or not the service was successful in meeting the need and advocating for improvements in service delivery. Monitoring includes at least monthly contacts with the consumer and with their service provider(s) and a home visit at least quarterly.

TYPES OF MONITORING

- Traditional telephone calls complemented with unannounced visits; this type of monitoring has two components:
  - yields information on services
  - yields information on functional changes
- Authority over payment to providers
- Agency requested by governmental entity such as county commissioners court to monitor with regards to funds they are paying directly to a non-governmental provider agency. Case management agency has no control over funds, rather acts as a consultant.
- Informal monitoring of clients referred to a provider that are not receiving case management services

MONITORING ROLES

- Validating that the provider agency is delivering the quantity and quality of service that it has promised
- Providing moral support and technical assistance to the provider
- Through telephone and in-person contacts, such as in-home visits, the case manager verifies that the consumer has taken the necessary steps to utilize the service authorized
- Teaching consumers and their family members to monitor their own caregivers
- Evaluating the effectiveness of service delivery in achieving the desired impact or outcome

FREQUENCY OF IN-HOME VISITS

- Intervals prescribed by the agency and during periods when providers are present
- At least one in-home visit per calendar quarter (requirement of Title III monies coming from Older American Act)
- Once a month (unscheduled) if possible, even when consumer's condition is stable; more frequent when condition is unstable
- Frequent telephone visits, as situation indicates
- Scheduled time for reassessment
- Following any major interruption such as hospitalization of consumer, loss of member of informal network, need for housing change, change in physical or mental status, change in financial situation

MONITORING INVOLVES COMMUNICATION WITH:

- Consumer and consumer's family
- Personnel with home health agencies, including hospice
- Personnel with providers of homemaker services
- Transportation providers
- Drivers delivering home delivered meals
- Grocery delivery personnel
- Physician
- Hospital social worker should consumer be in hospital

TEXAS DEPARTMENT ON AGING'S DESCRIPTION OF REASSESSMENT

Periodic reassessments are conducted either when the case manager's regular monitoring indicates that the consumer's condition has changed or when a caregiver reports to the case manager that the consumer's condition has changed. Reassessments include contacting the consumer, the family or friends or the service providers and applying case management procedures to newly discovered or still unmet needs.

COMMON REASONS FOR REASSESSMENT

- Medication interaction
- Change in informal network
- Acute health conditions causing hospitalization or temporary placement in a nursing home
- New crisis or impairment befalls the consumer
- Standardized intervals prescribed by agency policy
- On a schedule written into the care plan based upon the case manager's expectations
- When a new case manager is assigned to the case
- The presenting problem has been resolved
- Planned service is discontinued by consumer
- When there is planned withdrawal and a need to help the client to see the change in a positive light
- Agency pressure to terminate improved or stable cases to make way for new, waiting consumers.

ITEMS INCLUDED IN REASSESSMENT

- **Functional level of consumer**
- **Accuracy of care plan in addressing unmet needs**
- **Degree of accuracy of the match between the consumer's needs and what services the care plan provides**
- **Are the desired effects being achieved**
- **Modification of goals to include prevention**
- **The most cost effective approach used to meet functional needs**

COMMON REASONS FOR CASE CLOSURE

- The consumer himself/herself terminates
- The principal service provider recommends termination
- A single service provider accepts comprehensive responsibility for the care
- The consumer enters another living arrangement
- The consumer insists on services that the case manager thinks will be counterproductive or refuses recommended services
- The presenting problem has been alleviated and the case manager thinks that the client or caretaker can carry responsibility for service procurement and task coordination
- Demands for services and scarce resources make it necessary to set priorities among clients and withdraw services from those who can still benefit but whose needs are less hazardous than others

CLOSURE AS THE RESULT OF NURSING HOME PLACEMENT OR DEATH

- Confirm with the family/friends of the client that the information is correct
- Notify all service providers and community resource providers who were involved with the client
- Document why the case is closing and other pertinent details in the progress notes
- Process necessary paperwork to close the case

PURPOSE OF ONGOING COMMUNICATION

- Keeping the door open for former consumers whenever services are needed again
- Facilitating the referral by former clients of new clients
- Providing feedback to staff boosts their morale
- Providing ongoing moral support to consumers
- Supporting the ongoing service provider
- Ensure the earliest possible alert to consumers' pending discharge from a hospital or nursing home for which case management may be needed
- Giving "drop-out" or service-rejecting consumers a second chance. (Some older persons refuse service for fear that control of their lives will be taken out of their hands. After they have tested the agency's acceptance of their right to refuse, many will accept service when a second opportunity is offered.)

METHODS FOR MAINTAINING CONTACTS WITH CONSUMERS

- Referring consumer, before closure, to ongoing programs of telephone reassurance or friendly visiting whose workers are aware of the case management program should the need arise at a later time;
- Routine mailings of greetings at a holiday season, on the consumer's birthday or on the anniversary of leaving the program;
- Routine offering of a short-term service, for former as well as current consumers such as assistance with annual tax forms or senior discount identification cards;
- Periodic consumer satisfaction surveys or evaluation studies of consumer status.

REASONS FOR CONDUCTING EVALUATION OF CASE MANAGEMENT PROGRAM

- The need to comply with agency regulators (while not the best reason, it may realistically provide the highest motivation)
- The need to demonstrate agency accomplishments and effectiveness to funding sources
- The need to improve the practice of agency personnel including:
  - methods of allocating services
  - more accurate targeting of consumers and
  - enhanced supervision of case managers

BARRIERS TO EVALUATION

- An expectation that there will be an increase in the paperwork burden by case managers who believe themselves overburdened with paperwork.
- Associating evaluation with a language or skill level that is not in the vocabulary of many of the agencies' personnel, such as the language of statistics (*mean*, *median*, *mode*).
- The costliness of the evaluation activities in terms of both agency dollars and staff time.
- The resistance of service providers to evaluation based on the knowledge that their services are of high quality.
- The fact that evaluation reports are frequently not written for the case manager and seem to lack relevancy to daily practice concerns.

DETERMINANTS OF QUALITY CARE

- **Program Evaluation:**

  Examines the degree to which the services that were delivered had the desired effect. (Are seniors better off as a result of the services provided?)

- **Quality Assurance:**

  Examines how the desired outcomes can be assured across time and across a variety of settings with different case managers.

Components of Quality Assurance

- **Define the Service**
- **Develop Standards**

APPROACHES TO PROGRAM EVALUATION

- *Descriptive measures and indicators* that can provide a description of program components
- *Program review measures* that provide a qualitative review of case management practice
- *Program impact measures studies* that assess the extent to which specific outcomes have been accomplished for consumers receiving case management services

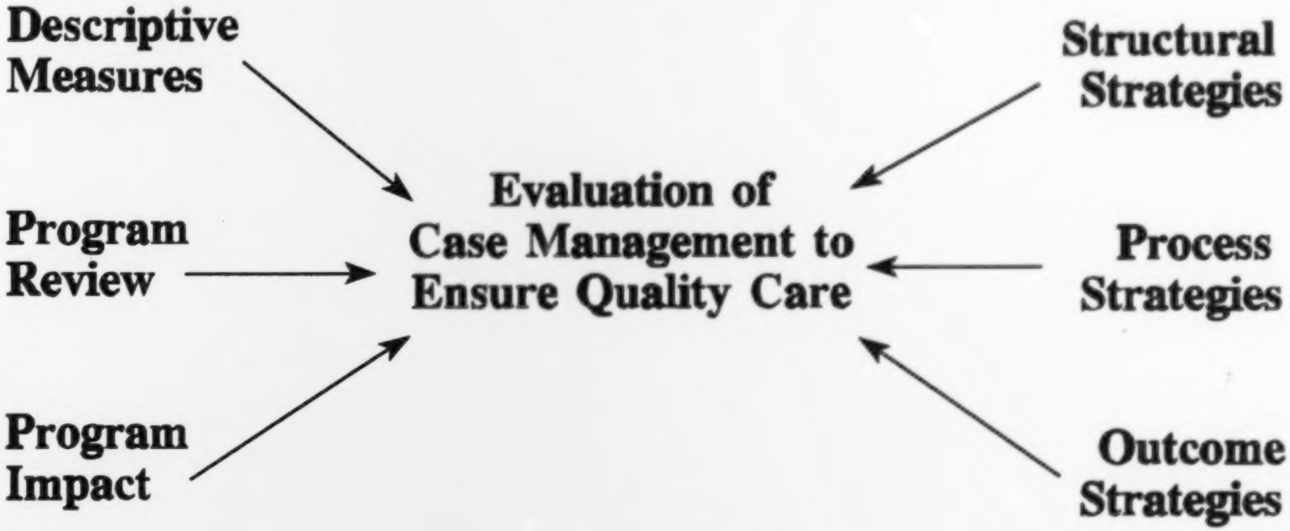
APPROACHES TO QUALITY ASSURANCE

- Structural Strategy
  - Agency Certification
  - Individual Licensure
  - Training Standards
  - Employee Relationships
  - Staffing Ratios (Case Mix Ratios)
  - Professional Credentialing

- Process Strategy
  - Developed Standards of Practice
  - Examines Records
  - Personal Observations
  - Interviews

- Outcome Strategy
  - Has the impact of the service on the consumer been positive.

BLENDING PROGRAM EVALUATION AND QUALITY ASSURANCE



- **Program Evaluation**
  - **Descriptive Measures**
  - **Program Review**
  - **Program Impact**

- **QualityAssurance**
  - **Structural Strategies**
  - **Process Strategies**
  - **Outcome Strategies**

Evaluation of Case Management to Ensure Quality Care

PRINCIPLES FOR CONDUCTING PROGRAM EVALUATION AND QUALITY ASSURANCE

- The case management agency must link its planning, administrative and evaluation practices together. Evaluation cannot be a separate activity.
- One individual within the agency should have primary responsibility for the evaluation function.
- The agency should involve a broad range of participants resulting in employees endorsing the effectiveness and importance of the process.
- The evaluation function must have a strong commitment from the agency's administration that includes the willingness to commit adequate resources necessary for the evaluation function.

DIFFERENCES BETWEEN HOME CARE AND INSTITUTIONAL CARE IN ENSURING QUALITY

- **Lack of Provider Control**
- **Private Homes are not designed as Care Environments**
- **Family Involvement complicates regulations**
- **Intermittent Service - providers cannot control what happens between visits**
- **Worker Isolation and Lack of Immediate, Onsite Supervision**
- **A Shared Responsibility for Quality of Life and Risk-Taking**

OUTCOMES OF QUALITY IN THE CONSUMER/PROVIDER RELATIONSHIP

- A rich and trusting relationship between the case manager, other care providers and the consumer
- The consumer both is and feels fully empowered to make choices about the nature and quality of the care
- Enables services to be uniquely tailored to meet the health and social care needs of the consumer

FOURTEEN POINTS OF TQM/CQI

- Create constancy of purpose for improvement of product and service.
- Adopt the new philosophy.
- Cease dependence on mass inspection.
- End the practice of awarding business on price tag.
- Improve constantly and forever the system of production and service.
- Institute training.
- Institute leadership.
- Drive out fear.

FOURTEEN POINTS OF TQM/CQI

(continued)

- Breakdown barriers between staff areas.
- Eliminate slogans and targets for the work force.
- Eliminate numerical quotas.
- Remove barriers to pride of workmanship.
- Institute a vigorous program of education and retraining.
- Take action to accomplish the transformation.

SEVEN DEADLY DISEASES IN THE DELIVERY OF GOODS AND SERVICES

- Lack of Constancy of Purpose
- Emphasis on Short-Term Results
- Evaluation by Performance, Merit Rating or Annual Review of Performance
- Mobility of Management
- Running a Company/Agency on Visible Figures Alone
- Excessive Medical Costs
- Excessive Costs of Warranty

KEY POINTS OF CQI

- It focuses on the system.
- It stresses that a quality process will result in quality outcomes.
- It expects active involvement from every level.
- It involves the consumer and all team members.
- It focuses on the management of systems.
- It expects decisions to be made based on data and recognizes variation in all processes.
- It has demonstrated that improved quality results in increased productivity.
- It is devoted to meeting and exceeding consumers' needs and expectations.

KEY PRINCIPLES OF CONTINUOUS QUALITY IMPROVEMENT

- **Consumer Focus**
- **Process Focus**
- **System Focus**
- **Teamwork**
- **Data Based Decision Making**
- **Continuous Improvement**

CONTRASTING QA & CQI

QA Focuses on:	CQI Focuses on:
● Achieving a Set Standard	● Continuous Improvement
● Problem Inspection at End of Process	● Problem Prevention
● What Happened/ What Went Wrong	● How it Happened
● External Audit by Inspector	● Internal Review
● Meeting Predefined Standards	● Quality Process

RECOMMENDATIONS ABOUT CONTINUOUS QUALITY IMPROVEMENT

- Ask consumer about what quality means to them (always).
- Define provider tasks based on detailed consumer choices.
- Empower consumers.
- Promote continuity of consumer/provider relationships.
- Help in-home workers appreciate the importance of their role and the value of their work in a consumer's life.
- Encourage workers to become problem-solvers and partners in the consumer's care plan.
- Take time for continuous quality improvement.